

1 UNITED STATES DISTRICT COURT
2 FOR THE NORTHERN DISTRICT OF OHIO
3 EASTERN DIVISION

4
5 IN RE: NATIONAL PRESCRIPTION)
6 OPIATE LITIGATION,)
7) MDL No. 2804
8)
9 THIS DOCUMENT RELATES TO:) Case No. 17-md-2804
10)
11 Track Three Cases)
12)

13 VIDEO-RECORDED DEPOSITION UPON ORAL EXAMINATION OF
14
15 ANNA LEMBKE, M.D.
16

17
18 11:27 A.M. EDT - 8:27 A.M. PDT
19 MAY 28, 2021
20

21 THIS DEPOSITION IS BEING TAKEN VIA VERITEXT
22 VIRTUAL/TELEPHONICALLY, AND ALL PARTIES, THE WITNESS,
23 AND COURT REPORTER ARE APPEARING REMOTELY
24

25 REPORTED BY: JUDY BONICELLI, RPR, CCR 2322, CSR 9091

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25 ALSO PRESENT: Lori Talbot, Videographer
Britt Cibulka

1 I N D E X

2 WITNESS: ANNA LEMBKE, M.D.

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5 By Ms. Allen 263

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7 EXHIBITS MARKED FOR IDENTIFICATION PAGE

8 Exhibit 1 Tab 12-An article dated 103

October 31, 2017, entitled "The
9 Opioid Epidemic is a Symptom of
Our Faltering Healthcare System"

10 Exhibit 2 Tab 13-America's Addiction 109

Epidemic: How Did We Get Here?

11 OSA with Dr. Anna Lembke

Exhibit 3 Tab 3-Section 1306.04, Purpose 160

12 of Issue of Prescription

Exhibit 4 Tab 8-SAMHAS In Brief article 273

13

14 CVS EXHIBITS MARKED FOR IDENTIFICATION

15 CVS Exhibit 1 A two-page document entitled 263

"How to Stop Drug Diversion
16 and Protect Your Pharmacy."
17
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1 FRIDAY; MAY 28, 2021

2 11:27 A.M. EDT - 8:27 A.M. PDT

3 --oOo--

4
5 THE VIDEOGRAPHER: We are on the record
6 at 8:27 a.m. on May 28, 2021. This deposition is being
7 conducted using virtual technology, and all
8 participants are attending remotely. Audio and video
9 recording will continue to take place unless all
10 parties agree to go off the record.

11 This is Media Unit 1 in the video-recorded
12 deposition of Dr. Anna Lembke, taken by Counsel for the
13 defendants in regards to National Prescription Opiate
14 Litigation filed in the United States District Court
15 for the Northern District of Ohio, Eastern Division,
16 MDL No. 2804, Case No. 17-MD-2804.

17 My name is Lori Talbot from the firm Veritext.
18 I am the videographer. The court reporter is Judy
19 Bonicelli from the firm Veritext. I'm not related to
20 any party in this action, nor am I financially
21 interested in the outcome.

22 If there are any objections to proceeding,
23 please state them at the time of your appearance, and
24 we'll begin with the noticing attorney, please.

25 MR. GISLESON: My name is John Gisleson

1 from Morgan, Lewis & Bockius on behalf of defendant
2 Rite Aid, and I will also be asking questions on behalf
3 of the pharmacy defendants.

4 MR. ARBITBLIT: Don Arbitblit, Lief
5 Cabraser, Heimann & Bernstein for plaintiffs.

6 MR. SHERIDAN: Thomas Sheridan, Simmons,
7 Hanly, Conroy for plaintiffs.

8 MR. CRAWFORD: Kyle Crawford from
9 Zuckerman Spaeder on behalf of the CVS defendants.

10 MR. STOFFELMAYR: Kasper Stoffelmayr for
11 the Walgreens defendants.

12 MS. GIBSON ALLEN: Good morning, this is
13 Erin Gibson Allen from Marcus & Shapira on behalf of
14 the defendant Giant Eagle.

15 MR. CARTER: Ed Carter from Jones Day
16 for Walmart.

17 MR. GISLESON: Will you swear the
18 witness, please?

19 THE VIDEOGRAPHER: Thank you.

20

21 ANNA LEMBKE, M.D.,

22 sworn as a witness by the Certified Court Reporter,

23 testified as follows:

24

25

1 EXAMINATION

2 BY MR. GISLESON:

3 Q. Good morning. Thank you for making time for
4 us, we appreciate it.

5 A. Of course.

6 Q. I know that you've had your deposition taken
7 multiple times, and that you know the rules, but just
8 so that we're on the same page, as you know, this is a
9 formal question and answer session where the court
10 reporter is taking down all the questions that I ask
11 and all the answers that you give. If at any time I
12 ask you a question that you do not hear, would you let
13 me know so that I can repeat the question?

14 A. Yes.

15 Q. If at any time I ask you a question that you
16 do not understand, would you let me know so that I can
17 rephrase the question?

18 A. Yes.

19 Q. And do you agree to only answer those
20 questions that you have heard and understood?

21 A. Yes.

22 Q. And can we have an agreement, a professional
23 understanding, that you will answer the specific
24 questions that I ask and not volunteer information that
25 goes beyond the scope of my questions?

1 MR. ARBITBLIT: I'll object to that.

2 The witness is entitled to interpret the question and
3 answer that she sees fits, and you're entitled to
4 interpose objections if you feel the answers are
5 inappropriate.

6 BY MR. GISLESON:

7 Q. Dr. Lembke, would you show me the professional
8 courtesy of asking -- answering these specific
9 questions that I ask?

10 A. I will do my best to answer your questions.
11 If I need to elaborate in order to best answer your
12 question, then I will elaborate.

13 Q. That's fine. Do you agree not to volunteer
14 information that goes beyond the scope of the question
15 or that is not necessary to elaborate?

16 A. I will do my best to answer your questions.

17 Q. Thank you very much. I appreciate that.

18 So what do you do for a living?

19 A. I am a physician.

20 Q. With whom?

21 A. I'm employed by the Stanford University School
22 of Medicine.

23 Q. What position do you hold?

24 A. I am professor. I am medical director of
25 Addiction Medicine. I am chief of the Addiction

1 Medicine Dual Diagnosis Clinic. I am program director
2 of the Addiction Medicine Fellowship.

3 Q. Sounds like you're busy. Can you give some
4 detail on what it is that you do?

5 A. I occupy the classic three-legged stool of
6 academic medicine. I spend about 75 percent of my time
7 seeing patients and mentoring trainees in the care of
8 patients. And I also teach and do research.

9 Q. Do you have any areas of specialization?

10 A. Yes.

11 Q. Can you describe what those are, please?

12 A. My areas include addiction medicine and
13 everything related to addiction medicine. I also have
14 expertise in treating pain with a courtesy appointment
15 in Stanford's Department of Pain and Anesthesia. I
16 have expertise in epidemiology, the opioid epidemic. I
17 have expertise in marketing as regards misleading
18 messages that instigated and significantly contributed
19 to the opioid epidemic. I have expertise in scheduled
20 drugs, the Controlled Substances Act. I have expertise
21 in surveillance systems to detect misuse, addiction,
22 and diversion, including prescription drug monitoring
23 system. Again, detecting red flags. I have expertise
24 in risk factors that contribute to addiction from an
25 environmental or health perspective.

1 Q. The expertise that you've developed, is that
2 in part a function of the patients that you have
3 treated in?

4 A. Yes.

5 Q. Is it also a function of the research and
6 writing that you have done?

7 A. Yes.

8 Q. And in particular, have you done a fair amount
9 of research and writing concerning the use of
10 prescription opioids for treating pain?

11 A. Yes.

12 Q. For the patients that you're seeing, what
13 percentage have a substance use disorder of some kind?

14 A. Approximately 80 percent.

15 Q. Of that 80 percent, approximately what
16 percentage has an opioid use disorder?

17 A. Approximately 50 percent.

18 Q. Now, you used the word "addiction." How does
19 addiction relate to a substance use disorder?

20 A. I use addiction synonymous with DSM language
21 for substance use disorder.

22 Q. Do you treat any patients who have pain who do
23 not have a substance use disorder?

24 A. Yes, I do.

25 Q. Can you describe that circumstance, please?

1 A. I treat a large number of patients who are
2 dependent, physically dependent, on opioids but do not
3 meet DSM-5 criteria for an opioid use disorder. I
4 treat patients who have previously been dependent on
5 opioids who have chronic pain who are no longer
6 physically dependent on opioids but continue to be seen
7 by me and in our clinic for their chronic pain, and I
8 have a number of patients who have neither opioid
9 dependence nor opioid use disorder but who do have
10 chronic pain who are treated by me and in my clinic.

11 Q. Do you consider chronic pain to be a real
12 medical condition?

13 A. Yes.

14 Q. Can you give examples -- strike that.

15 How do you define chronic pain?

16 A. Chronic pain is pain lasting most days beyond
17 the usual time of tissue healing, which is generally
18 defined as three months or more.

19 Q. In terms of chronic pain, what are the
20 different causes that you see for chronic pain? Strike
21 that.

22 What are some of the generally accepted cases
23 of chronic pain?

24 A. Injury to tissues, injuries to the nerves
25 themselves, and something called centralizing pain

1 disorder, which is the locus of disease in the brain
2 itself causing pain, so neuro-susceptive, neuropathic,
3 and centralizing.

4 Q. Now, you said that you've also written
5 concerning the prescribing and use of prescription
6 opioids. Have you done that in peer-reviewed
7 publications?

8 A. Yes.

9 Q. And can you describe what "peer review" means?

10 A. Peer review means that the article is reviewed
11 by a group of anonymous peers who have expertise in
12 that area.

13 Q. And then they have an opportunity to make
14 suggested changes or criticisms of what you've written?

15 A. Yes.

16 Q. And have you also written about the
17 prescribing and use of opioids in non-peer-reviewed
18 publications?

19 A. Yes.

20 Q. Why is the prescribing and use of prescription
21 opioids of interest to you personally?

22 MR. ARBITBLIT: Objection. Vague.

23 BY MR. GISLESON:

24 Q. You can answer.

25 A. Could you define what you mean by

1 "personally"?

2 Q. Sure. Do you consider yourself an advocate
3 for patients who have chronic pain?

4 A. I wouldn't use a loaded term like "advocate"
5 to describe my work.

6 Q. In terms of your focus on the use of
7 prescription opioids, has that been an important part
8 or component of your work?

9 A. My work has focused on the use of prescription
10 opioids, yes.

11 Q. And why did you focus your work on the use of
12 prescription opioids?

13 A. In the early 2000s, I was seeing patients
14 coming into my clinic who were dependent, misusing,
15 and/or addicted to the opioids that their doctors were
16 prescribing or had had a past history of such.

17 Q. And as a result of that, what did that cause
18 you to do?

19 A. I became concerned about the ways in which
20 opioids were being prescribed, dispensed, proliferating
21 in the community, and as a result, harming innocent
22 people.

23 Q. You wrote a book called "Drug Dealer M.D."; is
24 that right?

25 A. The full title is "Drug Dealer M.D., How

1 Doctors Were Duped, Patients Got Hooked, and Why It's
2 So Hard to Stop," yes.

3 Q. And did you write all the words in the book?

4 A. Yes, I did.

5 Q. And is that based on your accumulated research
6 and analysis of the prescribing use and effects of
7 opioid medications?

8 A. At that time, yes.

9 Q. Have you issued any written public statements
10 retracting any of the views or positions that you
11 asserted in your book?

12 A. I have qualified some of the statements in my
13 book since its publication in recognition of, you know,
14 the impacts that some of my statements have had, but I
15 haven't formally retracted anything in my book, no.

16 Q. What do you mean "you qualified some of the
17 statements in recognition of the impact it's had"?

18 A. I have had some people who read my comments
19 regarding fibromyalgia and expressed concern, and so
20 I've further qualified my position on that to try to
21 make it clearer if it wasn't clear from reading the
22 book.

23 Having said that, many of those individuals
24 didn't actually read my book. They just read tweets
25 about my book. Nonetheless, you know, in the spirit of

1 compassion, I have tried to make that aspect clearer.

2 Q. Anything else?

3 A. No.

4 Q. You graduated from Yale undergrad in 1989; is
5 that right?

6 A. Yes.

7 Q. And you also went to Stanford Medical School;
8 is that correct?

9 A. Yes.

10 Q. And you graduated in 1995?

11 A. Yes.

12 Q. Now, at that time, was Stanford considered one
13 of the top medical schools in the country?

14 A. I think so, yes.

15 Q. And has it consistently been considered one of
16 the top medical schools in the country from when you
17 attended in the early 1990s to the present?

18 A. Yes.

19 Q. And when you were in med school, certainly
20 they taught you how to prescribe opioid medications; is
21 that right?

22 MR. ARBITBLIT: Objection.

23 MR. GISLESON: Strike that.

24 BY MR. GISLESON:

25 Q. Did any of your medical training in medical

1 school involve the prescription of opioid medications
2 for pain?

3 A. Yes.

4 Q. When were you hired by plaintiffs' Counsel in
5 this case, by the plaintiffs' lawyers?

6 A. In 2017.

7 Q. When in 2017?

8 A. I believe it was the spring of 2017.

9 Q. In how many different cases have you issued
10 reports?

11 MR. ARBITBLIT: Objection as to
12 vagueness as to "issued" in terms of not disclosing
13 where Dr. Lembke has not been officially disclosed in
14 any particular case and which she might not know the
15 answer to that as to whether she's been disclosed. So,
16 Counsel, I'd just ask for a little understanding of
17 that. But I'm happy to recount them for you, if you
18 like.

19 MR. GISLESON: No thanks.

20 BY MR. GISLESON:

21 Q. So, Dr. Lembke, how many different cases have
22 you had your deposition taken?

23 A. I've been deposed in the MDL case. I've been
24 deposed in the New York case. I've been deposed in the
25 California Santa Clara case. And I believe I've been

1 deposed in the West Virginia case.

2 Q. Are you on retainer with the plaintiffs'
3 lawyers?

4 A. I don't know what "retainer" means.

5 Q. Have you been billing the plaintiffs' lawyers
6 for your time?

7 A. Yes.

8 Q. Have you been paid in full?

9 A. Yes.

10 Q. Can you approximate how much money you've
11 received to date from the plaintiffs' lawyers in the
12 different opioid cases?

13 A. I don't know.

14 Q. Can you estimate in any way?

15 A. It's more than \$100,000.

16 Q. Is it more than \$250,000?

17 A. Over the cumulative years, probably.

18 Q. Yes?

19 A. I'm not sure.

20 Q. Is it likely over \$500,000?

21 MR. ARBITBLIT: And I object just for a
22 moment, Counsel. I want to understand what you're
23 asking and see whether you are agreeing to reciprocal
24 information when you say "all of the opioid litigation"
25 as opposed to a particular case. Are you saying -- are

1 you committing that your experts will answer the same
2 question? Because if so, I will allow her to answer.
3 If not, I'll instruct her not to.

4 BY MR. GISLESON:

5 Q. Let me take a step back, then, before we get
6 to that. Approximately how much have you been paid for
7 writing your opinion in this case against the chain
8 pharmacy defendants?

9 MR. ARBITBLIT: Object to form.

10 THE WITNESS: I do not know.

11 BY MR. GISLESON:

12 Q. Throughout this deposition, I'll refer to the
13 chain pharmacy defendants or the pharmacy defendants or
14 defendants. Whenever I do that, I'm referring to CVS,
15 to Giant Eagle, to Rite Aid, to Walgreens, and to
16 Walmart. Do you understand that?

17 A. Yes, I do.

18 Q. And for the prior reports, you said you've
19 been deposed in four cases before this one, those cases
20 all focused on the manufacturers or the big three
21 distributors: AmerisourceBergen, Cardinal, and
22 McKesson; is that right?

23 A. Yes.

24 Q. And this is the first time in any opioid
25 litigation where you have expressed opinions concerning

1 dispensing of prescription opioid medications by
2 pharmacists as -- by pharmacies as defendants; is that
3 correct?

4 MR. ARBITBLIT: Object to form. Vague.
5 Are you talking about the written reports or in
6 testimony?

7 BY MR. GISLESON:

8 Q. We'll start with the written reports. This is
9 the first time in any opioid litigation where you have
10 expressed opinions concerning the dispensing of
11 prescription opioid medication by pharmacy defendants
12 in an opioid lawsuit, correct?

13 A. No, that is not correct.

14 Q. When was the other one?

15 A. The report for the distributor case has
16 opinions regarding pharmacy defendants.

17 Q. As to the distribution of opioid medications?

18 MR. ARBITBLIT: Object to form.

19 THE WITNESS: As to the collaboration
20 between distributors and pharmacy defendants.

21 BY MR. GISLESON:

22 Q. And we'll come back to that collaboration you
23 say. Now, is there a clinical definition for pain?

24 A. There are multiple clinical definitions for
25 pain.

1 Q. How do you define pain?

2 A. I -- is the question how do I define pain?

3 Q. Yes.

4 A. Pain is both a physical and emotional
5 experience of suffering as defined by the patient,
6 manifested in the body.

7 Q. Is there any way to objectively measure an
8 individual's pain?

9 A. No.

10 Q. You said that pain includes suffering as
11 defined by the patient. What do you mean "as defined
12 by the patient"?

13 A. Pain is highly subjective.

14 Q. So that in assessing an individual's pain,
15 it's necessary to look at the specific condition and
16 situation of the individual patient?

17 A. That is certainly part of what I would look
18 at, yes.

19 Q. Can an individual experience physical pain in
20 the absence of any identifiable disease process?

21 A. Yes.

22 Q. Can an individual experience pain in the
23 absence of a recognizable physical injury?

24 A. Yes.

25 Q. Now, prior to the 1980s, how were doctors

1 treating pain?

2 MR. ARBITBLIT: Objection. Vague.

3 BY MR. GISLESON:

4 Q. Dr. Lembke, based on your research and writing
5 as well as the training you've received, do you have an
6 understanding as to how doctors were treating pain
7 prior to the 1980s?

8 A. They were using a multimodal approach, and
9 they were using opioids very sparingly only for people
10 in severe distress, short-term, and at the very end of
11 life.

12 Q. What do you mean by "multimodal"?

13 A. They were using multiple different methods
14 including medications, but not exclusive to
15 medications. They were including various methods that
16 target pain in different ways other than medication.

17 Q. Why do you believe that the doctors were
18 prescribing opioid medication sparingly?

19 A. My research has shown that doctors were very
20 cautious when it came to opioid prescribing prior to
21 the 1980s and 1990s because they were concerned that
22 their patients would get addicted.

23 Q. What changed in terms of doctors' prescribing
24 practices with opioid medications for pain?

25 A. In the late 1990s, doctors began to prescribe

1 opioids for minor and chronic pain conditions as a
2 result of being duped by the opioid pharmaceutical
3 industry.

4 Q. What percentage of doctors, in your view, were
5 duped by the opioid pharmaceutical industry?

6 MR. ARBITBLIT: Objection. Vague.

7 BY MR. GISLESON:

8 Q. Take a step back.

9 Dr. Lembke, have you done anything to try and
10 quantify the number of doctors who in your view were
11 duped by the opioid pharmaceutical industry?

12 A. The research that I did for my book included
13 qualitative interviews with multiple providers who had
14 trained in different settings, across different years,
15 who had different specialties, and the majority of them
16 reported being duped by the opioid pharmaceutical
17 industry.

18 Q. Is it your belief that a majority of doctors
19 who were prescribing opioid medications were duped by
20 the opioid pharmaceutical industry?

21 A. Yes, it is.

22 Q. Were any doctors in Lake County or Trumbull
23 County, Ohio, duped into prescribing opioid
24 medications?

25 A. Since the campaigns to mislead doctors were

1 national campaigns, I have no reason to believe that
2 the doctors in Lake and Trumbull County were an
3 exception. So I think it's very likely that they too
4 were duped into overprescribing.

5 Q. Now, in terms of the standards for prescribing
6 opioid medications, we're obviously talking about
7 doctors. Do the same standards apply to nurse
8 practitioners, dentists, and physician assistants who
9 had prescriptive privileges to opioid medications as
10 applied to doctors?

11 MR. ARBITBLIT: Objection. Compound.

12 BY MR. GISLESON:

13 Q. Let me rephrase the question.

14 In terms of the prescription of opioid
15 medications for pain, how did the standards that
16 applied to doctors compare to the standards that
17 applied to other prescribers of opioid medications?

18 A. Could you define "other prescribers"?

19 Q. Sure. Nurse practitioners, physician
20 assistants, dentists, and anyone else who had a DEA
21 license that permitted them to prescribe opioid
22 medications.

23 MR. ARBITBLIT: Same objection.

24 THE WITNESS: The paradigm shift that
25 occurred in opioid prescribing beginning late 1990s was

1 a national paradigm shift. It shifted the culture in
2 medicine across the board around opioid prescribing,
3 and as such, I believe that anybody who prescribed
4 opioids was affected by that paradigm shift.

5 BY MR. GISLESON:

6 Q. When you talk about a paradigm shift, do you
7 mean that the medical standard of care for prescribing
8 opioid medications changed?

9 MR. ARBITBLIT: Objection.

10 THE WITNESS: No, I wouldn't use that
11 language.

12 BY MR. GISLESON:

13 Q. What do you mean by a paradigm shift?

14 A. I mean that it became commonly accepted for
15 opioids to be first-line treatment for many different
16 types of pain conditions, and that doctors were shamed
17 through the use of terms like "opioid phobia" and
18 quote, unquote, undertreatment of pain, into
19 prescribing more opioids and they were also misled into
20 believing that opioids are more effective than they
21 actually are and less risky than they actually are.

22 In particular, they were told that as long as
23 they were prescribing to a patient with a bona fide
24 pain condition, it was very unlikely or very rare that
25 that patient would become addicted to the opioid that

1 they were prescribing.

2 Q. What do you mean by first-line treatment?

3 A. Opioids became the go-to remedy for all
4 different types of pain.

5 Q. When you say it was commonly accepted for
6 opioids to be the first-line treatment for many
7 different types of pain conditions, does that mean that
8 there was a national practice in terms of the
9 circumstances under which prescription opioids
10 medications could be prescribed for pain?

11 MR. ARBITBLIT: Object to form.

12 (Reporter clarification.)

13 BY MR. GISLESON:

14 Q. Sorry.

15 With a paradigm shift, what was the medical
16 standard of care based on your research and analysis
17 for prescribing opioid medications for pain?

18 MR. ARBITBLIT: Objection.

19 THE WITNESS: I'm not sure how you're
20 defining the term "standard of care" or how you're
21 using that term in this question.

22 BY MR. GISLESON:

23 Q. Under what circumstances, once this paradigm
24 shift occurred, were doctors consistent, with their
25 professional medical responsibilities, permitted to

1 prescribe opioid medications for pain?

2 MR. ARBITBLIT: Objection.

3 THE WITNESS: Again, the way you frame
4 the question in terms of "permitted to prescribe," I'm
5 not quite sure what you're getting at or how best to
6 answer that.

7 BY MR. GISLESON:

8 Q. Did doctors violate any professional codes
9 applicable to the practice of medicine by prescribing
10 opioid medications for pain?

11 MR. ARBITBLIT: Objection. Overbroad.

12 THE WITNESS: Could you be more specific
13 about what codes you're referring to?

14 BY MR. GISLESON:

15 Q. Sure. Were there standards that applied to
16 doctors once this paradigm shift changed for when
17 opioid medications could be prescribed for pain?

18 MR. ARBITBLIT: Objection.

19 THE WITNESS: Yeah, what do you mean by
20 "standards"?

21 BY MR. GISLESON:

22 Q. As a medical doctor, you don't know what a
23 standard is when it comes to prescribing opioid
24 medications for patients?

25 MR. ARBITBLIT: Object to form.

1 Argumentative.

2 THE WITNESS: To me, that's a vague term
3 that is not commonly used among doctors. We don't talk
4 about standards.

5 BY MR. GISLESON:

6 Q. What word or phrase do you use to describe
7 what the protocol or practice is for prescribing opioid
8 medications for pain?

9 A. We talk about evidence-based medicine. We
10 talk about guidelines. We talk about quality measures.

11 Q. Once this paradigm shift occurred, in your
12 view, did doctors at that point have discretion to
13 prescribe opioid medications as a first-line treatment
14 for pain?

15 MR. ARBITBLIT: Objection. Overbroad.

16 THE WITNESS: Yeah, I'm not sure quite
17 what you mean by "did they have discretion."

18 BY MR. GISLESON:

19 Q. Did the medical profession, once this paradigm
20 shift occurred, make any effort to standardize the
21 prescribing of opioid medications for pain?

22 MR. ARBITBLIT: Objection. Overbroad.

23 THE WITNESS: It wasn't so much a matter
24 of standardizing. It was a matter of what the messages
25 were around the benefits and harms of opioids as well

1 as other incentives that would influence prescribing
2 one way or another.

3 BY MR. GISLESON:

4 Q. Your view was that the paradigm shift in
5 medicine toward liberal opioid prescribing has been a
6 major factor contributing to the increased supply that
7 fueled, in your view, the opioid epidemic; is that
8 right?

9 A. Yes.

10 Q. When you say that the paradigm shift was a
11 major factor contributing to the increased supply of
12 opioid medications, what do you mean?

13 A. I mean that through false and misleading
14 messages on the part of defendants, prescribers were
15 misled into believing that opioids are more effective
16 for the treatment of pain than they actually are, in
17 particular chronic pain, and that the risks of
18 prescribing, even at very high doses, even for very
19 long duration, were minimal.

20 Doctors were also told that pain was
21 undertreated, that it was essentially their fault
22 because they were not prescribing enough opioids; they
23 were opioid phobic. And doctors were furthermore
24 educated that because the chances of their patients
25 getting addicted to the opioids, they were prescribing

1 was very low, that they essentially needn't pay much
2 attention to that problem, and that if a patient
3 presented looking as if they might be developing an
4 addiction, they were actually pseudo-addicted and the
5 proper response was to go up on the opioids.

6 Q. So the change in -- strike that.

7 This paradigm shift then resulted in a larger
8 number of opioid medications being prescribed?

9 A. Yes.

10 Q. And in your view, were doctors acting in the
11 belief that there was a legitimate medical purpose for
12 prescribing opioids medications for pain?

13 MR. ARBITBLIT: Objection. Overbroad.

14 THE WITNESS: I do believe that the
15 majority of doctors believed that they were prescribing
16 for a legitimate medical purpose.

17 BY MR. GISLESON:

18 Q. When you say a majority, approximately how
19 many?

20 A. I couldn't really put a number on it.

21 Q. Can you estimate it in any way?

22 MR. ARBITBLIT: Objection.

23 THE WITNESS: Not beyond saying
24 majority.

25

1 BY MR. GISLESON:

2 Q. Is it your belief that a majority of the
3 prescribers in Lake and Trumbull Counties, Ohio,
4 believed that there was a legitimate medical purpose
5 for prescribing opioids for pain?

6 A. Because they were duped, I do believe that the
7 national campaign spread to every corner of America and
8 includes Lake and Trumbull Counties.

9 Q. And pain, in fact, had been undertreated is
10 that right?

11 A. Pain is still undertreated if you look at
12 outcomes, especially for chronic pain.

13 Q. Before the paradigm shift, had pain been
14 undertreated?

15 A. It really depends how you're defining
16 undertreatment.

17 Q. How do you define undertreatment as it existed
18 prior to the paradigm shift?

19 A. The truth is we have very poor treatments for
20 chronic pain, and in that sense, chronic pain is
21 undertreated because we don't have good treatments, but
22 I do not agree with the premise that opioids are
23 underprescribed or were underprescribed prior to the
24 1990s.

25 Q. For how long have there been poor treatments

1 for chronic pain?

2 A. To this day, we continue to have very limited
3 ability to effectively treat people with severe chronic
4 pain.

5 Q. Was there poor treatment for chronic pain both
6 before and after the paradigm shift?

7 A. Yes.

8 Q. Why, in your view, is there poor treatment for
9 chronic pain?

10 A. Modern medicine and modern science has yet to
11 figure out how to effectively treat chronic pain.

12 Q. Has that been a process of trial and error
13 from before the paradigm shift to the present?

14 MR. ARBITBLIT: Object to form.

15 THE WITNESS: I'm not sure what you mean
16 by "trial and error."

17 BY MR. GISLESON:

18 Q. Has the medical profession pursued different
19 approaches to the treatment of pain over time?

20 A. Well, the medical profession pursues different
21 treatments to all kinds of diseases for which there is
22 not good treatment.

23 Q. And that applies to pain?

24 A. Yes.

25 Q. Do you have any explanation, based upon the

1 research, analysis, and training you've done, as to why
2 it is that even until today modern medicine still has
3 not developed good treatment for chronic pain?

4 A. I'm sorry, could you restate the question?

5 Q. Do you have any understanding, based on the
6 research, analysis, and training that you have or have
7 performed, why it is that even to this point modern
8 medicine still does not have good treatment for chronic
9 pain?

10 A. Chronic pain is simply difficult to treat.

11 Q. Do doctors and other prescribers exercise
12 professional judgment in identifying what the
13 prescriber believes to be an appropriate course of
14 treatment for pain?

15 MR. ARBITBLIT: Object to form.

16 THE WITNESS: Prescribers and other
17 healthcare professionals can only exercise judgment if
18 they're exercising their judgment on facts and good
19 information. If they don't have access to the facts
20 and to the science, then they're not able to -- or to
21 the data, they're not able to exercise their judgment.

22 BY MR. GISLESON:

23 Q. Now, this paradigm shift affected your
24 generation of doctors?

25 A. Yes.

1 Q. Can you describe what you were taught in
2 medical school about pain?

3 A. I received a little training in medical school
4 about pain, not all that much, and the same is true for
5 addiction.

6 Q. Were you told at that time while in medical
7 school that pain was undertreated?

8 A. Yes, I believe so.

9 Q. And do you believe that that was occurring,
10 from the research you've done at medical schools all
11 across the country, that folks in medical school were
12 being told that pain was undertreated?

13 MR. ARBITBLIT: Objection.

14 THE WITNESS: I do believe that there
15 were messages in medical schools at that time that pain
16 was undertreated, yes.

17 BY MR. GISLESON:

18 Q. When you were in medical school, did Stanford,
19 one of the elite medical schools in the country at the
20 time, provide information to you about the risks
21 associated with prescribing opioid medications?

22 A. Very little.

23 Q. Why do you believe that was?

24 MR. ARBITBLIT: Objection.

25 THE WITNESS: The understanding of

1 addiction, especially to prescription medications, has
2 been relatively ignored in medical school education
3 until more recently.

4 BY MR. GISLESON:

5 Q. When you say, "more recently," when?

6 A. As I've written, one of the silver linings of
7 the tragedy of the opioid epidemic is that it has
8 forced medical schools to acknowledge the problem of
9 addiction and to recognize that addiction is disease
10 and that we, as healthcare providers, have a
11 responsibility to target and treat the disease of
12 addiction.

13 Q. When you were in medical school, were you
14 provided information about how to monitor for misuse or
15 abuse of prescription opioid medications?

16 A. Not that I recall, no.

17 Q. You mentioned that doctors were shamed into
18 prescribing opioid medications. Can you explain that?

19 A. Yes. Starting in the late 1990s, early 2000s
20 through multiple different educational pathways
21 including peer-reviewed literature, continuing medical
22 education, and drug reps showing up on our doorsteps,
23 Joint Commission standards, Federation of State Medical
24 Board standards, various guidelines of physicians, were
25 told, No. 1, that pain is undertreated, and No. 2, that

1 part of the reason that pain is undertreated is because
2 we, prescribers, are opioid phobic. And if we would
3 just prescribe opioids more liberally to our patients
4 in pain, then pain wouldn't be undertreated.

5 Q. Do you believe that that shaming, as you
6 describe it, had an effect on opioid prescribing
7 practices among doctors and other prescribers?

8 A. Yes, I do.

9 Q. That shaming came through professional medical
10 organizations to doctors?

11 MR. ARBITBLIT: Objection.

12 BY MR. GISLESON:

13 Q. Did any professional medical organizations
14 engage in shaming of doctors to cause them to prescribe
15 more opioid medications?

16 MR. ARBITBLIT: Objection.

17 MR. GISLESON: On what basis?

18 MR. ARBITBLIT: It's vague.

19 BY MR. GISLESON:

20 Q. Do you know what a professional medical
21 organization is, Dr. Lembke?

22 A. Yes.

23 Q. Did any professional medical organizations
24 engage in shaming of doctors?

25 A. Yes.

1 Q. Which ones?

2 A. The American Academy of Pain Medicine, the
3 American Pain Society, the Joint Commission, the
4 Federation of State Medical Boards.

5 Q. Do any of those have regulatory authority over
6 doctors who prescribe opioid medications?

7 MR. ARBITBLIT: Objection. Calls for a
8 legal conclusion.

9 BY MR. GISLESON:

10 Q. Do you have an understanding, based on your
11 own experience as a doctor and the research writing and
12 experience you have in the medical profession including
13 as to opioid medications, whether any of those entities
14 that you identify play a role in regulating doctors?

15 A. Well, they all played a role.

16 Q. And when you say they played a role in
17 regulating doctors, how?

18 A. Well, the Joint Commission is a very powerful
19 organization that sets quality measures that hospitals
20 have to follow in particular if they want to get Joint
21 Commission accreditation and receive Medicaid and
22 Medicare reimbursement. And the Joint Commission was
23 instrumental in propagating the idea of pain as a fifth
24 vital sign, including using material provided by them
25 by Purdue Pharma to train doctors on how to meet their

1 pain quality measures, including material that
2 reiterated many of the false and misleading messages
3 around opioids from the undertreatment of pain and
4 opioids being the answer to that, to the problem being
5 the doctors being opioid phobic, to pain being
6 effective for longer than it is effective and with less
7 risk. Those were all parts of the myths that were
8 propagated.

9 The Federation of State Medical Boards,
10 likewise, has an enormous influence on how physicians
11 practice. Physicians are very fearful of getting
12 citations or being sued if they violate the standards
13 of the Federation of State Medical Boards. And the
14 Federation of State Medical Boards collaborated with
15 opioid manufacturers to publish a book by Scott Fishman
16 called "Responsible Opioid Prescribing" as well as to
17 establish state guidelines around opioid prescribing,
18 all of which included pro-opioid messages that were
19 inconsistent with the science.

20 Professional medical societies like the
21 American Academy of Pain Medicine, the American Pain
22 Society, had many on their leadership committees and on
23 their board who were paid consultants by pharma. In my
24 report, I refer to the deposition of -- can I look at
25 my report for a moment?

1 Q. Of course.

2 A. I believe his name is Joel Saper, but he was a
3 member of those professional medical societies who from
4 the inside attested to the fact that the abstracts that
5 were chosen and the talks that were given were very
6 heavily influenced by what he called narcopharma.

7 Q. Do you consider those professional
8 organizations to have acted in the best interests of
9 the doctors that they were regulating?

10 A. No.

11 Q. Do you consider those professional medical
12 organizations to have acted in the best interest of the
13 patients who were being treated for pain by the doctors
14 who they regulated?

15 A. No.

16 Q. Well, didn't the academic institutions like
17 Stanford speak up and object to the Joint Commission or
18 the State boards of medicine with respect to what they
19 were instructing about the use of opioid medications
20 for pain?

21 A. Yes.

22 Q. How?

23 A. Well, I was one of the earliest voices from
24 inside the medical profession to talk about those very
25 things with the publication of my book and also, yeah,

1 with the publication of my book in 2016.

2 Q. Why, in your view -- strike that.

3 Now with all these different professional
4 medical organizations promoting the treatment of pain
5 with opioid medications, what effect did that have, in
6 your view, based on your research and your training, on
7 which specialties were prescribing opioid medications?

8 A. I have published on this topic, and I have
9 demonstrated that across all medical specialties,
10 doctors increased prescribing. This was not the result
11 of the small subset of so-called pill-mill doctors.
12 This was a paradigm shift across medical specialties.

13 Q. Were there any medical specialties that
14 refused to liberally prescribe opioid medications for
15 pain?

16 A. It essentially became impossible to refuse to
17 do that in the climate that was created in the early
18 2000s and continuing to some extent into the present
19 day.

20 Q. Were any of those medical organizations,
21 whether the state Board of Medicine or the Joint
22 Commission ever threatening disciplinary actions
23 against doctors who failed to treat a patient's pain?

24 A. Yes.

25 Q. To what extent did that happen?

1 A. In my book, I specifically refer to two cases
2 brought against individuals, prescribers in California,
3 who were sued for failing to adequately treat their
4 patient's pain.

5 Q. Sued by the medical board?

6 A. I think the plaintiffs were the individuals
7 who were allegedly harmed.

8 Q. The patients?

9 A. Yes.

10 Q. The Ohio Board of Medicine regulates doctors
11 who prescribe opioid medications in Ohio; is that
12 right?

13 A. Yes.

14 Q. Did the Ohio Board of Medicine similarly
15 encourage doctors in Ohio to liberally prescribe opioid
16 medications for pain?

17 A. Can I look at my report for a moment?

18 Q. Yes. If this is going to take a while,
19 Dr. Lembke, we can move on.

20 A. Yeah, I think I have something in my report.
21 I can't find it now. I can try to answer this question
22 later after having --

23 Q. I can go back to it. But is it your belief
24 that doctors in Ohio, like doctors elsewhere in the
25 country, felt under pressure to prescribe opioid

1 medications for pain?

2 A. Yes.

3 Q. And that was true for both acute pain as well
4 as chronic pain?

5 A. Yes.

6 Q. In terms of the medical specialties that were
7 prescribing opioid medications, did that include
8 primary care?

9 A. Yes.

10 Q. Oncology?

11 A. Yes.

12 Q. Surgeons and different disciplines?

13 A. Yes.

14 Q. Orthopedic doctors?

15 A. Yes.

16 Q. Geriatric doctors?

17 A. Yes.

18 Q. Dentists?

19 A. Yes.

20 Q. What other practice areas were prescribing
21 opioid medications for pain?

22 A. Many different types of doctors were and are
23 prescribing opioids for pain as well as non-M.D.
24 practitioners like nurse practitioners.

25 Q. Are there any other medical specialties that I

1 didn't identify that were also prescribing opioid
2 medications for pain?

3 A. Yes. If you look at my report, I do cite the
4 article that we published using a Medicare 2013
5 database, looking at who was prescribing opioids, and
6 there it includes a long list of the specialties,
7 longer than what you stated.

8 Q. Which practice areas or medical specialties
9 were prescribing the most opioid medications for pain?

10 MR. ARBITBLIT: Objection. Vague.

11 BY MR. GISLESON:

12 Q. Let me rephrase the question.

13 Did you do any analysis to determine who was
14 prescribing the most opioid medications by medical
15 specialty?

16 A. Yes.

17 Q. Who was it?

18 A. I'd like to look at that part of my report
19 just so I'm precise. I do remember, but I want to get
20 it just right.

21 Q. I think if you go to page 24 you wrote, "By
22 specialty, pain doctors prescribe more opioids than
23 doctors in any other specialties; however, by volume,
24 family medicine and internal medicine doctors account
25 for the most opioids because there are more of them."

1 I had trouble understanding the difference
2 about who was actually prescribing more. In terms of
3 MME, which is morphine milligram equivalent, which
4 specialty was prescribing more opioid medications?

5 MR. ARBITBLIT: Object to form.

6 BY MR. GISLESON:

7 Q. Okay. Let me rephrase the question.

8 When you wrote, "By specialty, pain doctors
9 prescribe more opioids than doctors in any other
10 specialties," what did you mean by "more opioids"?

11 A. By that it meant if you look at the number of
12 prescriptions per specialty, there are more pain
13 specialists -- the number is higher for pain
14 specialists. But if you look at the total number of
15 prescriptions written in the United States, there are
16 more for family medicine and internal medicine doctors
17 because there are more of those types of doctors.

18 Q. Was it within the scope of practice for the
19 family medicine and internal medicine doctors to
20 prescribe opioid medications for pain?

21 MR. ARBITBLIT: Object to form.

22 BY MR. GISLESON:

23 Q. Based on the research and analysis you've done
24 concerning opioid medication prescribing practices, did
25 you evaluate whether it was in the scope of practice

1 for family medicine and internal medicine doctors to
2 prescribe opioid medications for pain?

3 MR. ARBITBLIT: Object to form, vague.

4 THE WITNESS: I can't answer that as a
5 yes or no.

6 BY MR. GISLESON:

7 Q. Did you write any articles at any point
8 expressing the view that family medicine doctors and
9 internal medicine doctors should not be prescribing
10 opioid medications for pain?

11 A. I would not have stated it that simply because
12 it's not that simple.

13 Q. Why not?

14 A. Family medicine and internal medicine doctors
15 who work in a busy primary care practice where they
16 have 15 minutes to see a complex patient are not in a
17 position to prescribe opioids long-term and/or high
18 dose to a patient with chronic pain unless and if
19 they're also doing that in consultation with a pain
20 medicine doctor, and even then, there is not good
21 evidence to support the use of opioids long-term in the
22 treatment of chronic pain.

23 And the pressure, the time pressure, on
24 doctors to treat these patients, to have satisfied
25 customers, to deal with all that complexity, just

1 overburdens what could be possible for somebody to be
2 able to exercise good judgment and due diligence,
3 especially in light of the misleading messages that
4 primary care doctors were exposed to and have been
5 exposed to.

6 Q. Have you analyzed why it was that family
7 medicine and internal medicine doctors who had only 15
8 minutes to see a complex patient were prescribing
9 opioid medications for pain without consulting a pain
10 specialist?

11 A. Yes, I have.

12 Q. What did you find?

13 A. I found that the opioid pharmaceutical
14 industry heavily targeted primary care doctors to
15 prescribe more opioids and that that influence that
16 they exercised was effective.

17 Q. By "opioid pharmaceutical industry," do you
18 mean manufacturers?

19 MR. ARBITBLIT: Objection.

20 THE WITNESS: I mean -- as I state in my
21 report, I mean manufacturers, distributors, and
22 pharmacies.

23 BY MR. GISLESON:

24 Q. Can you identify any chain pharmacy defendant,
25 CVS, Giant Eagle, Rite Aid, Walgreens, or Walmart who

1 targeted a prescriber anywhere in Ohio to encourage
2 that prescriber to write opioid medication
3 prescriptions?

4 A. These were national campaigns that targeted
5 doctors everywhere in the United States, and that would
6 include Ohio and Lake and Trumbull Counties.

7 Q. My focus, Doctor, is on the chain pharmacy
8 defendants. Can you identify any chain pharmacy
9 defendant that specifically targeted doctors to
10 encourage those doctors to prescribe opioid
11 medications?

12 A. Yes.

13 Q. Who?

14 A. Let me look at my report.

15 Q. We'll come back to that, Doctor, to save time.

16 A. I'm happy to give examples, but happy to come
17 back to whatever you like.

18 Q. Yeah, unfortunately, I'm time-constrained.
19 Although if Counsel would like to give me a second day,
20 we can go into more detail. I'll come back and pick it
21 up later.

22 Now, you said that in your report, and I think
23 you've already testified to this here, that opioid
24 overprescribing isn't really the result of a small
25 subset of high volume or pill-mill prescribers, but it

1 was much broader than that throughout the medical
2 profession. Have you analyzed any or identified any
3 pill-mill prescribers in Lake or Trumbull Counties?

4 A. No.

5 Q. Do you agree that a prescriber, whether a
6 doctor a dentist or someone else who has a high-volume
7 practice for opioid prescriptions, can still issue
8 those prescriptions for legitimate medical purpose?

9 MR. ARBITBLIT: Object to form.

10 THE WITNESS: It would really depend on
11 how high volume.

12 BY MR. GISLESON:

13 Q. In your view, what is such a high volume that
14 it is impossible for the doctor to be issuing those
15 prescriptions for legitimate medical purpose?

16 A. Well, it wouldn't just include an assessment
17 of the volume or a sudden increase in the volume from
18 prior prescribing. It would also include assessing the
19 nature of the relationship between the prescriber and
20 the patient as well as whether or not the opioid was
21 issued for a legitimate medical condition.

22 Q. So in your experience, it's not enough just to
23 look at the total number of opioid prescriptions that a
24 prescriber is issuing, you need to look specifically at
25 the individual patient?

1 MR. ARBITBLIT: Object to form.

2 THE WITNESS: No.

3 BY MR. GISLESON:

4 Q. Is that fair?

5 A. No, I wouldn't say that's fair. I would say
6 at some point if the volume is so great it trumps other
7 considerations because of the public health impact and
8 the public nuisance that very high volumes of opioids
9 in society can create.

10 Q. Is there any standard, based on the research
11 you've done, as to the point at which the volume of
12 opioid prescriptions is so great that it trumps other
13 considerations because of the public health impact?

14 A. There is consensus now in medicine that the
15 quadrupling of the supply of opioids between the late
16 1990s and approximately 2012 was causative in the
17 quadrupling of admissions to treatment programs for
18 opioid addiction and opioid-related overdose deaths.

19 So given that broad consensus and the
20 appreciation for the causal nature of those phenomena,
21 I think that most people in the medical profession
22 would agree that once you're doubling, tripling,
23 quadrupling the supply in a very short of amount of
24 time in a specific region, you're contributing to a
25 public nuisance.

1 Q. Doctor, I don't mean to be rude, but I need to
2 move to strike that answer because it really wasn't
3 responsive to my question. The question is, is there
4 any standard based on the research you've done for when
5 a particular prescriber's volume of opioid
6 prescriptions is so great that it trumps all other
7 considerations as to whether that prescriber is issuing
8 those prescriptions for legitimate medical purpose?

9 MR. ARBITBLIT: Object to form.

10 THE WITNESS: I think for a standard for
11 that, one could look at some of the DEA regulations in
12 certain regions that have identified high prescribing
13 and how they define that.

14 BY MR. GISLESON:

15 Q. Can you identify a specific number that the
16 DEA has identified by regulation as to what the volume
17 is that is so great that the prescriber can no longer
18 be issuing legitimate medical -- strike that.

19 Can you identify any DEA regulation anywhere
20 in the country that specifically identifies a
21 particular volume of opioid prescriptions that renders
22 a prescriber's prescriptions not to have a legitimate
23 medical purpose?

24 A. Well, there are federal regulations regarding
25 the prescribing of the opioid buprenorphine limiting

1 that to initially 30 patients and then later more than
2 100 patients in recognition of the fact that specific
3 limits do have an impact on the public nuisance or the
4 harm to the public health.

5 Q. So there should be a regulation that the
6 plaintiffs can point to in this case that would
7 identify what that specific volume is of prescriptions
8 that is so high the prescriber's prescriptions can no
9 longer have legitimate medical purpose?

10 MR. ARBITBLIT: Object to form.

11 THE WITNESS: Sorry, could you repeat
12 the question to me? It was hard to understand. I
13 wasn't sure how it linked to what I said previously.

14 BY MR. GISLESON:

15 Q. Based on your answer, there should be a
16 regulation issued by the DEA someplace that identifies
17 what the standard is for when a prescriber's volume of
18 opioid prescriptions is so high that the prescriber can
19 no longer have a legitimate medical purpose for issuing
20 the prescriptions?

21 MR. ARBITBLIT: Objection.

22 Argumentative. Misstates the record.

23 THE WITNESS: No, I didn't say that.

24 BY MR. GISLESON:

25 Q. Now, you mentioned a couple of times a

1 "legitimate medical purpose." What, in your
2 experience -- and we'll talk about since the paradigm
3 shift -- was a legitimate medical purpose based on the
4 pronouncements of the various medical organizations for
5 issuing an opioid medical prescription for pain?

6 MR. ARBITBLIT: Objection. Vague.

7 BY MR. GISLESON:

8 Q. Do you know what a legitimate medical purpose
9 is when it comes to prescribing opioid medications?

10 MR. ARBITBLIT: Objection. Vague.

11 THE WITNESS: I do have a section in my
12 report where I talk about the legitimate use of opioids
13 based on the evidence.

14 BY MR. GISLESON:

15 Q. I'm not talking about the evidence. I'm
16 talking about the paradigm shift. Under the paradigm
17 shift, what were legitimate medical purposes for
18 prescribing opioid medications for pain?

19 MR. ARBITBLIT: Objection.
20 Argumentative. Vague.

21 THE WITNESS: The way that opioids have
22 been prescribed since the late 1990s have been, in many
23 instances, not legitimate because they were not
24 informed by science.

25

1 BY MR. GISLESON:

2 Q. I understand that's your position, but the
3 question is, for these different medical specialties
4 who were issuing prescriptions for pain, what were the
5 legitimate medical purposes that were recognized among
6 those different specialties for issuing opioid
7 prescriptions?

8 MR. ARBITBLIT: Objection. Vague.
9 Argumentative. Asked and answered.

10 THE WITNESS: Yeah, I feel like I
11 answered that question.

12 BY MR. GISLESON:

13 Q. But you didn't.

14 MR. ARBITBLIT: Argumentative. Not a
15 question.

16 BY MR. GISLESON:

17 Q. You said before that you believe the majority
18 of prescribers were issuing prescriptions because they
19 believed that there was a legitimate medical purpose
20 for the opioid prescription; is that right?

21 A. Yes.

22 Q. And from your research and analysis, what were
23 the legitimate medical purposes that those prescribers
24 were using in connection with issuing the
25 prescriptions?

1 MR. ARBITBLIT: Objection. Vague.
2 Misstates the record. Do you want to rephrase it so
3 that they believe they were legitimate, that would be
4 different from trying to mislead the witness into
5 saying they were legitimate without the belief.

6 MR. GISLESON: Please stop coaching the
7 witness.

8 MR. ARBITBLIT: Please stop asking
9 repetitive, argumentative questions.

10 BY MR. GISLESON:

11 Q. Dr. Lembke?

12 A. Yes.

13 Q. You said that in your view at least the
14 majority of prescribers nationally were writing opioid
15 prescriptions because they believed that those
16 prescriptions had a legitimate medical purpose. What
17 did you understand those legitimate medical purposes to
18 be?

19 MR. ARBITBLIT: Objection.
20 Argumentative.

21 THE WITNESS: As I said before, they
22 believed that they were writing opioid prescriptions
23 for a legitimate medical purpose because they were
24 duped, when in fact, their prescribing was not
25 legitimate because it was not informed by the science.

1 BY MR. GISLESON:

2 Q. In terms of legitimate medical purpose, was
3 that pain?

4 MR. ARBITBLIT: Object to form.

5 THE WITNESS: That would be an
6 overstatement of my opinion and too broad.

7 THE VIDEOGRAPHER: This is Lori, the
8 videographer, and I'm sorry to interrupt but I just
9 want to let you know that Hunter entered the room, and
10 I'm not completely familiar with attorneys so I just
11 wanted to let you know. Thank you.

12 BY MR. GISLESON:

13 Q. Now, once this paradigm shift occurred, were
14 the prescribers expected to exercise professional
15 medical judgment in deciding whether to prescribe
16 opioid medications?

17 MR. ARBITBLIT: Object to form.

18 THE WITNESS: They were -- they had
19 great difficulty exercising appropriate medical
20 judgment for a number of different reasons.

21 BY MR. GISLESON:

22 Q. That wasn't my question. Were prescribers
23 expected to exercise professional judgment in issuing
24 prescriptions for opioid medications?

25 MR. ARBITBLIT: Objection. Vague.

1 THE WITNESS: Again, I think it's
2 important in order to understand the truth of the
3 matter that it was nearly impossible for doctors to
4 exercise their clinical judgment when they were not
5 given accurate information about the true risks and
6 benefits.

7 BY MR. GISLESON:

8 Q. Move to strike as nonresponsive.

9 Are you trained to exercise judgment when you
10 were in medical school when it came to issuing opioid
11 medications?

12 MR. ARBITBLIT: Object to form.

13 THE WITNESS: I think every professional
14 person will try to exercise their best judgment if
15 their intentions are good. But it's impossible to
16 exercise your judgment if you don't have the data that
17 you need to make a good decision.

18 BY MR. GISLESON:

19 Q. When doctors were prescribing opioid
20 medications for what they believed to be legitimate
21 medical purposes, what were the different areas where
22 they were exercising judgment?

23 MR. ARBITBLIT: Object to form.

24 BY MR. GISLESON:

25 Q. Do you have an understanding, Doctor, as to

1 the process by which doctors should undergo during the
2 time that this paradigm shift occurred for evaluating
3 whether to prescribe an opioid medication for pain?

4 MR. ARBITBLIT: Object to form.

5 THE WITNESS: I'm not sure I understand
6 what you mean by "process."

7 BY MR. GISLESON:

8 Q. Is it your view that once the paradigm shift
9 occurred, that doctors believed they could simply issue
10 opioid medication prescriptions without evaluating an
11 individual patient's specific medical condition and
12 needs?

13 MR. ARBITBLIT: Object to form.

14 THE WITNESS: First of all, the paradigm
15 shift occurred in an iterative process. It was
16 cumulative. It didn't happen overnight. And secondly,
17 I do believe that the false and misleading messages and
18 the enormous pressure on physicians to address the
19 epidemic of undertreated pain and to overcome their
20 opioid phobia overwhelmed their ability to exercise
21 their clinical judgment.

22 BY MR. GISLESON:

23 Q. Is that true for all of the prescribers in the
24 United States?

25 MR. ARBITBLIT: Object to form.

1 THE WITNESS: That's not what I said. I
2 think that is overstating it.

3 BY MR. GISLESON:

4 Q. What analysis -- strike that.

5 What is the standard that you applied in
6 saying that prescribers all across the United States
7 were overwhelmed in their ability to exercise clinical
8 judgment when it came to prescribing opioids?

9 MR. ARBITBLIT: Object to form.

10 THE WITNESS: I base that on my own
11 medical education, on my own exposure to these
12 misleading messages, and to the various pressures to
13 prescribe opioids. I base that on my research that I
14 did for my book. I base that on my review of the
15 documents that were available to me through discovery,
16 and I base that on my review of the medical literature
17 and the evidence on the benefits and risks of opioids
18 and how that differs from the messages that were being
19 amplified and promulgated across medicine in a way that
20 made it virtually impossible for physicians to exercise
21 their clinical judgment because of the enormous
22 pressure on them to prescribe more opioids.

23 MR. ARBITBLIT: Counsel, we've been
24 going for 75 minutes, do you have a natural stopping
25 point for a break?

1 MR. GISLESON: Yeah, we can take a
2 break.

3 MR. ARBITBLIT: Do you want to keep it
4 to ten minutes, try to move along?

5 MR. GISLESON: Yeah, that's fine.

6 MR. ARBITBLIT: Thank you.

7 THE VIDEOGRAPHER: We are going off the
8 record at 9:46.

9 (Recess taken 9:46 p.m. to 9:57 p.m.)

10 THE VIDEOGRAPHER: We are back on the
11 record. The time is 9:57. Please proceed.

12 BY MR. GISLESON:

13 Q. Dr. Lembke, we were talking about the
14 different professional medical organizations that were
15 responsible for this paradigm shift. Do you have your
16 book "Drug Dealer M.D." handy?

17 MR. ARBITBLIT: Object to form. Object
18 to the prelude. That wasn't part of the question and
19 move to strike it.

20 BY MR. GISLESON:

21 Q. Dr. Lembke, you referenced the Joint
22 Commission as well as the various Federation of State
23 Medical Boards. What I would like to do is turn to
24 your book. Am I holding up a copy of your book?

25 A. Mr. Gisleson, you froze in the middle of that.

1 Can you restate the comment or question?

2 Q. Sure. Does this appear to be a copy of your
3 book?

4 A. Yes, that is a copy of my book.

5 Q. And can you hold up your copy of the book to
6 make sure that we're both on the same book, same page.
7 Thanks. If you can go to page 72, please. The first
8 full paragraph you wrote, "Big medical was the engine
9 by which" --

10 THE VIDEOGRAPHER: Counsel, your audio
11 is cutting out.

12 BY MR. GISLESON:

13 Q. Dr. Lembke, if you turn to page 72 of your
14 book, the first full paragraph --

15 A. I'm sorry, your audio is cutting in and out.

16 MR. ARBITBLIT: Can't hear you, Counsel.

17 MR. CARTER: I was going to say why
18 don't we go off the record, you know, hang up and then
19 dial back in for you.

20 MR. GISLESON: Can you hear me?

21 MR. ARBITBLIT: We can hear you now.

22 MR. GISLESON: Okay, great.

23 BY MR. GISLESON:

24 Q. So Dr. Lembke, turning to your book on page 72
25 in the first full paragraph, you wrote in the first two

1 sentences, "Big medicine was the engine behind the
2 opioid paradigm shift and big pharma, the stealthy and
3 powerful caboose. Big medicine provided legitimacy and
4 big pharma the funds to push the message along."

5 That is an accurate statement of what you
6 wrote?

7 A. It is what I wrote, yes.

8 Q. And then if we go to the prior page, please,
9 you see on that page there is a heading for the engine
10 and the caboose; is that right?

11 A. Yes.

12 Q. And if we look at the last paragraph on that
13 page, you wrote, "Manufacturers of opioid painkillers
14 have contributed to the opioid epidemic that has
15 ravaged the United States, but blame cannot be placed
16 on big pharma alone." And your reference there to big
17 pharma refers to the manufacturers in that paragraph,
18 correct?

19 A. Yes.

20 Q. You then write, "Blame lies with doctors as
21 well, especially those in academia and other positions
22 of leadership who ignored the" --

23 A. Oh, you froze again.

24 Q. Again --

25 (Reporter clarification.)

1 MR. GISLESON: Can you hear me?

2 BY MR. GISLESON:

3 Q. Let me start over again. I apologize.

4 Dr. Lembke, so you wrote at the bottom of
5 page 71 under the heading, "The Engine and the Caboose,
6 manufacturers of opioid painkillers have contributed to
7 the opioid epidemic that has ravaged the United States,
8 but blame cannot be placed on big pharma alone. Blame
9 lies with doctors as well, especially those in academia
10 and other positions of leadership who ignored the
11 evidence on risk and efficacy in pursuit of their own
12 agenda, an agenda that originated in a desire to help
13 but then lost its way."

14 So that when you criticize academia, are you
15 criticizing your own people at Stanford and other
16 medical schools around the country?

17 MR. ARBITBLIT: Object to form.

18 BY MR. GISLESON:

19 Q. Who did you encompass by your use of the word
20 "academia"?

21 A. I was mainly referring to key opinion leaders
22 who were paid by the opioid pharmaceutical industry to
23 promote pro-opioid messaging departing from the
24 evidence.

25 Q. Key opinion leaders in academia?

1 A. Many of them are from academia, not all.

2 Q. And when you say "academia," you're referring
3 to medical schools?

4 A. I'm referring to people who are leaders in the
5 field who publish articles that influence the field,
6 who speak at continuing medical education that
7 influences the field.

8 Q. You then write, "Blame also lies with
9 regulatory agencies like the Federation of State
10 Medical Boards, the Joint Commission, and the FDA."

11 That's the big medicine to whom you're
12 referring?

13 MR. ARBITBLIT: I'll object. You can't
14 just stop in the middle of the sentence, Counsel. I'll
15 object to the form of that. You want to read the rest
16 of the question, or should the witness read it?

17 MR. GISLESON: No.

18 BY MR. GISLESON:

19 Q. Dr. Lembke, you refer to big medicine was the
20 engine behind the opioid paradigm shift. The big
21 medicine, as you reference in that paragraph, is
22 Federation of State Medical Boards, the Joint
23 Commission, and the FDA; is that correct?

24 MR. ARBITBLIT: Object to form.

25 THE WITNESS: So this is a paragraph

1 that is speaking of different entities that have some
2 blame in the opioid epidemic. And I mention multiple
3 different entities, including the Federation of State
4 Medical Boards, the Joint Commission, and the FDA. But
5 those are not the exclusive entities that constitute
6 big medicine.

7 BY MR. GISLESON:

8 Q. If you turn to page 57 of the book, in terms
9 of big pharma, you write on page 57 in the second full
10 paragraph, "What began as a good faith effort to
11 improve the lives of patients in pain, soon gave way to
12 an epidemic of opioid painkiller overprescribing. The
13 pharmaceutical industry, big pharma, specifically the
14 makers of opioid painkillers like OxyContin, Purdue
15 Pharma, played a pivotal role in the epidemic."

16 And that's still your view, correct?

17 A. It is my view that the pharmaceutical industry
18 also includes distributors and pharmacies.

19 Q. That's not what you wrote in this big, is it?

20 A. No, at the time I wrote this book I had not
21 researched the role of distributors and pharmacies to
22 the extent that I have now.

23 Q. Well, in your 156-page book, you never, not
24 even once, blame any chain pharmacy defendant for the
25 opioid crisis, correct?

1 A. In my 2016 book, that's correct.

2 Q. And you certainly knew it at the time you were
3 writing this book that pharmacies were dispensing
4 opioid medications pursuant to prescriptions that were
5 being issued by doctors who briefed that they had a
6 legitimate medical purpose for doing so, right?

7 MR. ARBITBLIT: Object to form.

8 THE WITNESS: At the time I wrote this
9 book, yes, I understood how pharmacies work.

10 BY MR. GISLESON:

11 Q. Do you view Purdue Pharma as being culpable
12 for the opioid epidemic?

13 A. Yes.

14 Q. And your reference when you say, "the
15 pharmaceutical industry, big pharma, specifically the
16 makers of opioid painkillers like OxyContin," you're
17 referring to manufacturers of opioid medications,
18 right?

19 A. In my book, that is correct.

20 Q. And in fact, right now, you're appearing in a
21 TV show for HBO called "Crime of the Century"; is that
22 right?

23 A. It's a documentary, yes.

24 Q. And it's a documentary about the Sackler
25 family who owned or started Purdue Pharma?

1 A. Yes.

2 MR. ARBITBLIT: Objection.

3 BY MR. GISLESON:

4 Q. And your view was that Purdue Pharma and the
5 Sackler family have significant culpability,
6 responsibility, for the opioid epidemic; is that right?

7 A. As I've stated in my book and in my report,
8 there is lots of blame to go around, but certainly
9 Purdue has played an important role in the creation of
10 the opioid epidemic. They are not the sole actors,
11 however.

12 Q. And it was Purdue Pharma that, in your view,
13 was making false messages or giving false messages of
14 substantial benefit and low risk of opioid medications?

15 MR. ARBITBLIT: Object to form.
16 Misstates the testimony.

17 BY MR. GISLESON:

18 Q. Strike that. Did Purdue Pharma issue messages
19 to doctors of substantial benefit and low risk of
20 opioid medications?

21 A. Purdue was not alone in promoting misleading
22 messages, but yes, Purdue was responsible for
23 misleading messages as well.

24 Q. Can you go to page 128 of your book, please?
25 You have a section on page 128 that starts, "Doctors as

1 Baristas"; is that correct?

2 A. Yes.

3 Q. And these are your views based on your
4 education, training, and experience as a doctor who
5 speaks publicly as well as researches extensively
6 issues relating to the opioid epidemic; is that right?

7 MR. ARBITBLIT: Objection. Object to
8 form.

9 THE WITNESS: I'm sorry. Could you
10 restate the question?

11 BY MR. GISLESON:

12 Q. Sure. Are the views that you express in the
13 first paragraph under "Doctors as Baristas" ones that
14 are based on your education, training, experience, and
15 research relating to the prescription of opioid
16 medications?

17 A. Can you just give me a moment to read the
18 paragraph?

19 Q. Actually, why don't you read it out loud,
20 please?

21 MR. ARBITBLIT: Why don't you read the
22 whole thing. She's got the right to read it before she
23 starts reading out loud, Counsel. Take your time.

24 THE WITNESS: Would you like me to read
25 it out loud now?

1 BY MR. GISLESON:

2 Q. Please.

3 A. "The current prescription drug epidemic is not
4 the result of the small population of deviant doctors
5 willfully harming patients, although those doctors
6 exist. Rather, it is the result of a large population
7 of well-intended doctors working in healthcare
8 factories that prioritize throughput of body parts on
9 an assembly line over whole patient health. The result
10 is overprescribing, which is faster and better
11 reimbursed than educating or empathizing with patients.

12 "Pills that are addictive are particularly
13 likely to be overprescribed because they provide
14 patient customers with short-term satisfaction and a
15 proxy for human attachment, but not necessarily
16 improved health.

17 "When autonomy is truncated and professional
18 status is linked to" --

19 (Reporter clarification.)

20 A. -- "earning power, in patient satisfaction
21 surveys, doctors are vulnerable to objectifying
22 patients as commodities rather than seeing them as
23 people. Patients are vulnerable to utilizing doctors
24 as nothing more than a source of drugs."

25 Q. You refer to the concept of the Toyotaization

1 of medicine. Is that what you're describing here?

2 A. Yes, in part.

3 Q. Could you describe what you mean by the
4 Toyotaization of medicine?

5 A. What I mean is that doctors -- the majority of
6 doctors now work as salaried employees for large
7 institutions and their practice is very heavily
8 dictated by many pressures inside that institution,
9 including pressures to see patients more quickly,
10 pressures to have satisfied customers with rating
11 surveys.

12 It is very common that a patient will have
13 multiple doctors for multiple different healthcare
14 problems, making it difficult to know, despite you
15 know, electronic medical record, exactly what kind of
16 care a patient is receiving from another provider or
17 exactly what kind of medication they're being
18 prescribed, which can result inadvertently in dangerous
19 drug-drug combinations or overprescribing.

20 The bottom line is that in many ways, doctors
21 have lost an enormous amount of autonomy. They're
22 subject to Joint Commission quality measures, pain
23 guidelines and other guidelines promulgated by
24 professional medical societies and other different
25 entities that essentially dictate how doctors practice

1 and how they prescribe medications.

2 Q. Does that apply to how they prescribe opioid
3 medications for pain?

4 A. Yes.

5 Q. Do you blame those institutions for creating
6 that environment for doctors and other prescribers?

7 A. As I've stated in my book and in my report,
8 there is lots of blame to go around, but the opioid
9 pharmaceutical industry was really the key instigating
10 factor for this paradigm shift.

11 Q. Move to strike. Nonresponsive. Doctor, I'm
12 not trying to be rude.

13 You're talking about those institutions that
14 were putting pressure on doctors to prescribe opioid
15 medications. What were the institutions?

16 A. Well, the institutions included the opioid
17 pharmaceutical industry that essentially both directly
18 targeted doctors with an aggressive sales force and
19 aggressive marketing campaign, but also targeted
20 patients and targeted the various institutions that I
21 mentioned inside of medicine that were promoting
22 opioids.

23 Q. When you wrote that "the current prescription
24 drug epidemic is not the result of a small population
25 of deviant doctors willfully harming patients, although

1 those doctors exist, rather it is the result of a large
2 population of well-intended doctors working in
3 healthcare factories that prioritize throughput of body
4 parts on an assembly line over whole patient health,"
5 what are the "healthcare factories" that you reference
6 there?

7 A. Large, integrated healthcare centers where
8 most physicians work today.

9 Q. Is that around the country?

10 A. Yes, it is.

11 Q. Including those institutions in Ohio?

12 A. Yes.

13 Q. Do you consider the Cleveland Clinic to also
14 be guilty of what you describe in this paragraph?

15 A. Yes.

16 Q. Could you go to page 26 of your report,
17 please? If you look under Item No. 4, you wrote, "The
18 pharmaceutical opioid industry contributed
19 substantially to the paradigm shift in opioid
20 prescribing through misleading messaging about the
21 safety and efficacy of prescription opioids. The
22 industry disseminated these misleading messages through
23 an aggressive sales force, key opinion leaders, medical
24 school curricula, continuing medical education courses,
25 clinical decision support tools, professional medical

1 societies, patient advocacy groups, and the Federation
2 of State Medical Boards and the Joint Commission"; is
3 that right?

4 A. Yes, that's what it says there.

5 Q. Now, in terms of the aggressive sales force,
6 did any of the chain pharmacy defendants -- aggressive
7 sales force that targeted doctors in Trumbull and Lake
8 Counties?

9 A. I'm sorry, but you froze in the middle. Can
10 you restate the question?

11 Q. Sure. Did any of the chain pharmacy
12 defendants use a sales force, which you describe as
13 aggressive sales force, in Lake County or Trumbull
14 County to target doctors?

15 A. They collaborated with the sales force that
16 was employed by the opioid manufacturers.

17 Q. That was not my question, Doctor. The
18 question is, did the chain pharmacy defendants have an
19 aggressive sales force that themselves targeted
20 prescribers in Lake and Trumbull Counties?

21 A. To some extent the pharmacists themselves
22 functioned as a sales force.

23 Q. Did the chain pharmacy defendants have a
24 formal sales force that targeted defendants -- that
25 targeted prescribers by going to their offices --

1 MR. ARBITBLIT: Object to form.

2 BY MR. GISLESON:

3 Q. -- and encouraging them to prescribe opioid
4 medications?

5 A. As far as I know, the pharmacy defendants did
6 not specifically hire drug reps who went to patients'
7 offices, but they used many other methods to
8 collaborate with those drug reps to promote false and
9 misleading messages to prescribers and to patients.
10 And the pharmacists themselves functioned as laundered
11 intermediaries to promote false and misleading
12 messaging.

13 Q. Move to strike as nonresponsive.

14 Who employed the drug reps?

15 A. The drug reps as -- I guess I would ask how
16 are you using that term, drug reps?

17 Q. Who employed the drug reps?

18 MR. ARBITBLIT: Objection. Asked for
19 clarification.

20 THE WITNESS: What -- yeah, what do you
21 mean by "drug reps"?

22 BY MR. GISLESON:

23 Q. Have you never heard of a drug rep?

24 A. Of course I have, but I want to make sure you
25 and I are using the same definition.

1 Q. Someone employed by a pharmaceutical
2 manufacturer to promote its drugs --

3 MR. ARBITBLIT: Object to form.
4 BY MR. GISLESON:

5 Q. -- to doctors directly.

6 A. Okay. Thank you. Can you repeat your
7 question?

8 Q. Sure. Did any of the chain pharmacy
9 defendants employ drug reps to make sales calls on
10 doctors who were prescribing opioid medications?

11 A. Not directly. But they did collaborate with
12 those drug reps.

13 Q. How did any chain pharmacy defendant in Ohio
14 collaborate with manufacturer's drug reps to contact
15 prescribers in Ohio?

16 MR. ARBITBLIT: Object to form.

17 THE WITNESS: On page 79 of my report,
18 romanette 6.

19 BY MR. GISLESON:

20 Q. So on that page you write, "Walgreens allowed
21 Purdue sales reps to make calls on Walgreens healthcare
22 supervisors who oversaw 70 to a hundred retail stores";
23 is that right?

24 A. That's one example, yes.

25 Q. That's not a target to a doctor, is it?

1 Strike that.

2 That does not involve any Walgreens employee
3 speaking with a doctor to encourage that doctor to
4 prescribe opioid medications, correct?

5 A. Well, Walgreens pharmacists speak with doctors
6 on a daily basis, so what drug reps disseminate to
7 pharmacists is very likely to be further disseminated
8 to doctors.

9 Q. What factual basis do you have to say that a
10 pharmacist for any of the chain pharmacy defendants in
11 Ohio in fact communicated a manufacturer's message
12 concerning opioid medications to a prescriber in Ohio?

13 MR. ARBITBLIT: Object to form.

14 THE WITNESS: On page 97 of my report, I
15 talk about how Rite Aid pharmacy "collaborated with the
16 American Pain Foundation, a patient advocacy
17 organization funded largely by the pharmaceutical
18 opioid industry to create a patient-facing educational
19 pamphlet on pain to ensure customers receive the kind
20 of information that will make a difference and" --

21 BY MR. GISLESON:

22 Q. That does not involve targeting doctors with
23 an aggressive sales force, is it?

24 Doctor, the only aggressive sales force you
25 can identify is the one that was the drug reps working

1 for an opioid manufacturer, correct?

2 A. As I've stated before, the pharmacy defendants
3 closely collaborated with the opioid manufacturers
4 including the drug reps to propagate the same false and
5 misleading messages.

6 Q. Move to strike as nonresponsive.

7 Doctor, the only aggressive sales force you
8 can identify is the one where the drug reps were
9 working for an opioid manufacturer, correct?

10 MR. ARBITBLIT: Object to form.

11 THE WITNESS: Again, I would argue that
12 the pharmacies themselves became an aggressive sales
13 force.

14 BY MR. GISLESON:

15 Q. You have no factual basis to say that any
16 chain pharmacy defendant in fact made sales calls on
17 prescribers in Ohio encouraging those prescribers to
18 prescribe more opioid medications, correct?

19 A. I'm not aware of pharmacy defendant employees
20 themselves going to doctors' offices, but in other ways
21 by direct to patient promotion, and frankly, by
22 promoting the false and misleading messages to their
23 own pharmacists, they did propagate this
24 misinformation.

25 Q. Move to strike the second part of the answer

1 as nonresponsive.

2 Doctor, if you look at page 27 of your report,
3 you have the heading "For Aggressive Sales Force"?

4 A. Yes, I do.

5 Q. You wrote, "As explained below, the
6 pharmaceutical opioid industry retained an aggressive
7 sales force incentivized to target doctors' offices and
8 pharmacies to increase sales, thereby increasing the
9 number of people exposed to opioids." Is that correct?

10 A. That's what I wrote there, yes.

11 Q. And by the reference to "incentivized to
12 target pharmacies," that includes chain pharmacy
13 defendants, correct?

14 A. Yes.

15 Q. In the next paragraph you wrote, "In 2012, the
16 pharmaceutical industry spent \$15 billion on
17 face-to-face sales and promotional activity. These
18 face-to-face promotional activities rely primarily on
19 sales representatives and" --

20 A. I'm sorry, you cut out in the last little bit.

21 Q. After sales --

22 (Reporter clarification.)

23 Q. How about now? Can you hear me? Sometimes
24 when I click on mute and then unmute, that helps.

25 If you look at the second paragraph that you

1 wrote under "aggressive sales force," you wrote that
2 "In 2012, the pharmaceutical industry spent \$15 billion
3 on face-to-face sales and promotional activity. These
4 face-to-face promotional activities rely primarily on
5 sales representatives," in parentheses you wrote drug
6 reps, "who market their products directly to doctors'
7 offices and pharmacies." Is that right?

8 A. Yes, that's what I wrote there.

9 Q. If you turn, please, to page 37, you made
10 reference to key opinion leaders as being ones who were
11 trying to drive this paradigm shift; is that right?

12 A. Yes.

13 Q. And the key opinion leaders were ones who were
14 hired by the opioid manufacturers in your view,
15 correct?

16 A. The key opinion leaders were also hired by the
17 pharmaceutical defendants.

18 Q. Well, you wrote, "to encourage doctors to
19 prescribe more opioids, opioid manufacturers promoted
20 the careers of physicians who were sympathetic to their
21 cause"; is that correct?

22 A. That's what I wrote there, yes, but on page 83
23 of my report I talk about, for example, Walgreens'
24 Brody, a pharmacist, being promoted as a key opinion
25 leader to create pharmacy superstores."

1 And also getting back to your earlier question
2 regarding whether or not these agents had direct
3 contact with doctors, I do say in romanette 12 in the
4 middle of page 83 quoting from Walgreens' pharmacist
5 Brody that the "doctors will have the assurance that
6 the pain meds will be filled by a pharmacist less
7 likely to question his or her prescribing habits,"
8 unquote.

9 Q. Do you realize, Dr. Lembke, that what you're
10 citing there are internal Purdue emails?

11 A. Yes, I do.

12 Q. Did you speak with any of the individuals at
13 Purdue who participated in that email exchange?

14 A. No.

15 Q. Do you know whether the Purdue individuals who
16 were involved in that email exchange accurately
17 recorded what they discussed with Walgreens during
18 those meetings?

19 MR. ARBITBLIT: Object to form.

20 BY MR. GISLESON:

21 Q. Do you know whether the individuals --

22 A. Frozen again.

23 Q. Do you know whether the Purdue individuals --
24 and their interactions with Walgreens and Mr. Brody?

25 A. I'm sorry, can you say it again? You cut out.

1 Q. Do you know whether the Walgreens individuals
2 who participated in that internal Purdue -- strike
3 that.

4 Do you know whether the Purdue individuals who
5 participated in the internal email exchanges accurately
6 described what they were told by Mr. Brody?

7 MR. ARBITBLIT: Objection.

8 THE WITNESS: I've not seen anything to
9 the contrary.

10 BY MR. GISLESON:

11 Q. What investigation, if any, did you do into
12 whether the Purdue individuals accurately recounted any
13 conversations they had with Mr. Brody?

14 A. I reviewed thousands of documents. I've not
15 seen anything to dispute this account.

16 Q. And you also have not seen anything to
17 demonstrate that the internal Purdue individuals
18 accurately described the conversation with Mr. Brody,
19 correct?

20 MR. ARBITBLIT: Object to form.

21 THE WITNESS: I have no reason to
22 question their description of the interactions with
23 Mr. Brody.

24 BY MR. GISLESON:

25 Q. So in your view, in your experience, it's

1 reliable to you -- strike that.

2 In your experience you think it's reasonable
3 to rely on what Purdue Pharma -- wrote in internal
4 emails?

5 A. You cut out in the middle. Sorry, can you say
6 that again?

7 Q. Sure. Based on all the different documents
8 you've read and the research you've done, do you think
9 it's reasonable to rely on the accuracy and veracity of
10 what internal Purdue representatives write in emails
11 about their interactions with pharmacies and others?

12 MR. ARBITBLIT: Object to form.

13 THE WITNESS: My review of Purdue's very
14 internal private documents has led me to believe that
15 those internal and private email exchanges are some of
16 the most revealing regarding Purdue's strategies and
17 what they knew when and generally how they went about
18 marketing opioids.

19 BY MR. GISLESON:

20 Q. You also refer to CMEs or continuing medical
21 education. Who was presenting the CMEs that you
22 reference?

23 A. Well, as pertains to the defendants, I have a
24 whole section on the kinds of continuing medical
25 education provided to pharmacists that were created in

1 close collaboration in many instances with opioid
2 manufacturers and perpetuated the same false and
3 misleading messages.

4 Q. It was the manufacturers who were providing
5 the continuing medical education to the prescribing
6 doctors; is that correct?

7 A. No. On page 84, I specifically reference a
8 Walgreens University document from 2017 where Purdue
9 was, in fact, Walgreens' student at this continuing
10 medical education event.

11 Q. What year was that?

12 A. That was 2017, Walgreens University 2017.

13 Q. Any other examples you can identify?

14 A. Yes. Brody was a pharmacist, key opinion
15 leader for Walgreens, who spoke at continuing medical
16 education conferences for pharmacists. Page 85 of my
17 report, Rite Aid collaborated with Purdue to provide
18 multiple in-service programs to pharmacists that
19 promoted opioid use under the guise of, quote, "proper
20 pain management education." And then below, I describe
21 that continuing medical education in more detail.

22 Q. Does any of this provide any continuing
23 medical education to the prescribing doctors in Ohio?

24 A. This is continuing medical education for the
25 pharmacists.

1 Q. Did any of the chain pharmacy defendants
2 provide continuing medical education to prescribing
3 practitioners in Ohio concerning opioid medications?

4 A. Not formally that I know of.

5 Q. In your experience, it was the manufacturers
6 who were providing the continuing medical education to
7 the prescribing doctors for opioid medications; is that
8 right?

9 A. Yes, in parallel with the pharmacy defendants
10 describing similarly misleading continuing medical
11 education for pharmacists.

12 Q. You're assuming, aren't you, that the
13 pharmacists themselves knew that what they were saying
14 was false as to the safety and efficacy of opioid
15 medications, correct?

16 A. I'm assuming no such thing.

17 Q. So you don't know whether the chain pharmacy
18 defendants believed in good faith that prescribing
19 opioid medications for chronic pain was a legitimate
20 medical purpose?

21 MR. ARBITBLIT: Object to form.

22 THE WITNESS: I'm sorry, could you
23 rephrase the question?

24 BY MR. GISLESON:

25 Q. You do not know whether the chain pharmacy

1 defendants believed in good faith that prescribing
2 opioid medications for chronic pain was a legitimate
3 medical purpose?

4 MR. ARBITBLIT: Object to form.

5 THE WITNESS: My reading of the evidence
6 is that the pharmacy defendants were indifferent to the
7 legitimate -- the legitimate or illegitimate purpose of
8 the opioids that they were dispensing. They were
9 primarily focused on profit motives.

10 BY MR. GISLESON:

11 Q. Objection. Move to strike as nonresponsive.

12 You also refer to clinical decision support
13 tools -- relating to opioid medications?

14 A. I'm sorry, you cut out in the middle. Can you
15 restate that question, if there was one?

16 Q. Sure. On page 53 of your report, you refer to
17 clinical decisions support tools. What are they?

18 A. Those are things like nudges in the electronic
19 medical record to encourage certain types of
20 prescribing. Those are things like posters on the
21 walls of exam rooms encouraging using certain tools to
22 assess the patient.

23 Q. Those were provided by pharmaceutical
24 manufacturers?

25 A. The ones that I'm aware of, yes, although --

1 I'll just leave it at that.

2 Q. I'll have you turn to page 59, please, of your
3 report. You also believe that the Federation of State
4 Medical Boards was involved with changing the paradigm
5 of care for opioid medications, and if we look on
6 page 59 under the Federation of State Medical Boards,
7 item Roman Numeral II, you wrote, "In 1998, the FSMB,
8 Federation of State Medical Boards, released a policy
9 to reassure doctors that they would not be prosecuted
10 for the treatment of pain. Further, the FSMB urged
11 state medical boards to punish doctors for
12 undertreating pain. Doctors lived in fear of
13 disciplinary action from the state medical boards and
14 the lawsuit that usually followed if they denied a
15 patient opioid painkillers."

16 Was that true in Ohio?

17 A. Yes.

18 Q. Was that true around the country --

19 A. I'm sorry, you froze again in the middle.

20 Q. Was that true around the country as well? Was
21 that true around the country as well?

22 A. Yes.

23 Q. You also wrote that, "In 2007 the FSMB
24 published a book promoting the use of opioid
25 painkillers. This book was sponsored by a consortium

1 that included Abbott Laboratories, Alpharma
2 Pharmaceuticals --

3 (Reporter clarification.)

4 Q. -- Cephalon, Inc., Endo Pharmaceuticals, and
5 the University of Wisconsin Pain and Policy Study
6 Group; is that correct, Doctor?

7 A. Yes.

8 Q. And those are manufacturers other than the
9 University of Wisconsin Pain and Policy Study Group,
10 correct?

11 A. Yes.

12 Q. On page 60, you refer to changes in the law in
13 Ohio and that in 1998, Ohio passed the Intractable Pain
14 Act; is that right?

15 A. Yes.

16 Q. And in your view, what effects did the Ohio
17 Intractable Pain Act in 1998 have on the prescription
18 of opioid medications for pain?

19 A. As I state in my report, it essentially opened
20 the floodgates for doctors to treat chronic pain with
21 prescription opioids.

22 Q. So the Ohio legislature effectively encouraged
23 prescribers to issue prescriptions for opioid
24 medications for pain?

25 A. They did take some actions that led to that,

1 yes.

2 Q. The Joint Commission, you had mentioned them
3 as well, and that's on page 62 of your report. You
4 said, "The Joint Commission accredits healthcare
5 organizations and programs including in hospitals." Is
6 that right?

7 A. You froze in the middle. Sorry.

8 Q. "The Joint Commission is an organization that
9 accredits hospitals and other medical healthcare
10 organizations"; is that right?

11 A. Yes.

12 Q. Now, you say that "In 2001, the Joint
13 Commission made pain the fifth vital sign alongside
14 heart rate, temperature, respiratory rate, and blood
15 pressure."

16 Did the Joint Commission making pain the fifth
17 vital sign have an effect on prescribing opioid
18 medications?

19 A. Yes, as did pharmacy defendants' promotion of
20 those Joint Commission quality measures.

21 Q. Move to strike the second part of that
22 referring to the pharmacies.

23 The Joint Commission has control over whom in
24 the American healthcare system?

25 MR. ARBITBLIT: Object to form.

1 THE WITNESS: The Joint Commission
2 accredits hospitals; a lot of hospitals need and want
3 Joint Commission accreditation because it's part of how
4 they get reimbursed.

5 BY MR. GISLESON:

6 Q. So that the Joint Commission was establishing
7 guidelines, then, for these hospitals for the
8 prescription of opioid medication?

9 A. Well, the Joint Commission specifically
10 emphasized certain misleading messages around opioids
11 that would contribute to this paradigm shift, and they
12 specifically used Purdue Pharma material to do that,
13 messages like pain is undertreated, and opioids are the
14 answer, and doctors are opioid phobic, and doctors need
15 to do everything in their power to address a patient's
16 pain or they're reneging on their responsibility as
17 healthcare providers.

18 Q. Did the Joint Commission receive any funding
19 from Purdue?

20 A. I'm not recalling if they received direct
21 funding, but they did use Purdue Pharma marketing
22 material, and they sold that material to hospitals so
23 the hospitals could try to meet the Joint Commission
24 quality standards.

25 Q. Then all these different organizations, in

1 your view, contributed to the paradigm shift, which in
2 turn led to overprescribing, in your view, of opioid
3 medications; is that right?

4 MR. ARBITBLIT: Object to form.

5 THE WITNESS: The pharmacy defendants
6 would be in that group of individuals and organizations
7 that contributed to the paradigm shift that led to the
8 opioid epidemic, yes.

9 BY MR. GISLESON:

10 Q. Move to strike as nonresponsive.

11 Do you agree that the prescription drug
12 epidemic, in your view, is first and foremost an
13 epidemic of overprescribing?

14 A. It's an epidemic of the oversupply of opioids,
15 and one of the important ways that opioids get into
16 society is through a doctor's prescription.

17 Q. Move to strike as nonresponsive.

18 Do you agree the prescription drug epidemic is
19 first and foremost an epidemic of overprescribing?

20 A. I would say it's an epidemic of
21 overprescribing, overdistribution, and overdispensing.

22 Q. Go to your book, please at page 25. Under an
23 "Epidemic of Overprescribing," you wrote, "The
24 prescription drug epidemic is first and foremost an
25 epidemic of overprescribing." Is that correct?

1 A. That's what I wrote here.

2 Q. And you also said, "The extent to which
3 doctors rely on prescription drugs, especially
4 scheduled drugs, to treat their patients for even
5 routine, non-life-threatening medical conditions is
6 unprecedented."

7 That was an accurate statement then when you
8 wrote the book, correct?

9 A. I'm sorry, where is that?

10 Q. In the same paragraph. "But today, the extent
11 to which doctors rely on prescription drugs, especially
12 scheduled drugs, to treat their patients for even
13 routine, non-life threatening medical conditions is
14 unprecedented," correct?

15 A. Yes, that's what I wrote there.

16 Q. Would you turn to page 57, please, of your
17 book. In the first full paragraph on page 57 you
18 write, "In the early 1980s, however, professional
19 medical opinion on the use of opioid pain relievers
20 began to change in favor of using opioids more
21 liberally."

22 That was an accurate statement based on your
23 research; is that right?

24 A. I think I would clarify that a little bit by
25 saying that there were individuals and publications as

1 early as the 1980s and probably even before that were
2 promoting more liberal use of opioids. But it really
3 didn't take off until the late 1990s when the
4 pharmaceutical opioid industry amplified those
5 messages.

6 Q. You then write, "The number of patients living
7 with pain was growing due to an aging population, to
8 more people undergoing and surviving complicated
9 surgeries, and to more people being kept alive with
10 life-threatening illnesses." And then you also say
11 that hospice care was beginning to develop. Is that
12 right?

13 A. Yes.

14 Q. And those were all accurate explanations as to
15 why there was an increase in chronic pain in the United
16 States, true?

17 A. Yes, but it doesn't follow that there should
18 have been an increase in opioid prescribing.

19 Q. Were doctors in the 1980s and 1990s, based on
20 the research you've done, aware that the number of
21 patients living with pain was growing?

22 A. I think that doctors became more aware that in
23 the 1990s and early 2000s.

24 Q. Were doctors also aware in connection with
25 prescribing prescription opioid medications that there

1 was an aging population that was experiencing chronic
2 pain?

3 A. Yes. Again, I think doctors began to be aware
4 of that.

5 Q. Could you go to page 19 of your report,
6 please? You say in Paragraph No. 3, "Opioid
7 prescribing began to increase in the 1980s and became
8 prolific in the 1990s and the early part of the 21st
9 century representing a radical paradigm shift in the
10 treatment of pain and creating more access to opioids
11 across the United States."

12 You then write under B1, "From 1996 to 2011,
13 there was a 1,448 percent increase in the medical use
14 of opioids with increases of 690 percent from 1995 to
15 2004 and 100 percent from 2004 to 2011."

16 What did you mean by "medical use"?

17 A. That the main way that the oversupply was
18 occurring was through the flooding of prescription
19 opioids obtained through a prescription or otherwise
20 diverted.

21 Q. You then wrote, "Over the same time period,
22 opioids misuse increased more dramatically,
23 4,680 percent from 1996 to 2011, with increases of
24 1,372 percent from 1996 through 2004, and 245 percent
25 from 2004 to 2011."

1 When you talk in terms of misuse, that's a
2 patient's failure to use the opioid medication as
3 prescribed by the healthcare provider?

4 MR. ARBITBLIT: Object to form.

5 BY MR. GISLESON:

6 Q. What do you mean by "misuse" --

7 A. So misuse --

8 Q. -- in that sentence?

9 A. So misuse is a term that is used differently
10 in different contexts. Sometimes misuse is very
11 strictly defined as a patient using an opioid
12 medication in any way other than prescribed, which
13 could include, for example, the doctor saying take one
14 pill in the morning and one at night and instead the
15 patient takes one pill at noon and one at night.

16 But that's not the definition that I'm talking
17 about here. I'm talking about the kind of misuse which
18 is consistent with early signs and symptoms of an
19 opioid use problem.

20 Q. And that is true even with prescriptions that
21 were issued for legitimate medical purpose, that a
22 patient could still misuse them despite the legitimate
23 medical purpose?

24 A. Again, I think you and I probably are not
25 going to come to agreement on the term of "legitimate

1 medical purpose" because I want to be very clear that
2 although doctors were prescribing opioids for minor and
3 chronic pain conditions, that wasn't really a
4 legitimate use of the opioids. It wasn't
5 evidence-based that they were duped into doing that,
6 but, yes, I can agree that many of the problems of
7 misuse, if not the majority, came -- that those
8 individuals who were misusing opioids got them directly
9 or indirectly from a doctor's prescription.

10 Q. And to be fair, it's your view that opioid
11 medication should never be used for long-term chronic
12 pain; is that right?

13 MR. ARBITBLIT: Object to form.

14 THE WITNESS: That is not true. I have
15 not said that, and in my report as well as in public
16 forums where I've spoken on this topic, I have
17 specifically said that there may be a very small subset
18 of individuals who might benefit from the use of
19 opioids long-term in the treatment of chronic pain, but
20 those individuals would be the rare exception.

21 BY MR. GISLESON:

22 Q. Do the majority of prescribers even today
23 still prescribe opioid medications for long-term
24 chronic pain?

25 MR. ARBITBLIT: Object to form.

1 THE WITNESS: So prescribers --

2 BY MR. GISLESON:

3 Q. Strike that.

4 What percentage of prescribers today prescribe
5 opioid medications for long-term chronic pain?

6 A. So prescribers today are caught between a rock
7 and a hard place in that there are millions of
8 opioid-dependent chronic pain legacy patients who are
9 now physically dependent on opioids, and it would be
10 inhumane to just simply cut them off because they would
11 go into debilitating and even potentially
12 life-threatening opioid withdrawal.

13 So many ongoing prescriptions for opioids in
14 the treatment of chronic pain are actually in harm
15 reduction strategy to prevent debilitating withdrawal
16 and part of a taper strategy as doctors attempt to get
17 these high-dose, long-term chronic pain patients to
18 lower, safer doses.

19 Q. Can you explain what you mean by "taper"?

20 A. Taper means to lower the dose of a medication
21 over time. Taper usually implies that is done at a
22 pace that the patient can tolerate.

23 Q. So in your view, a doctor should not just cut
24 off a patient from opioid medication prescriptions when
25 the patient has an opioid use disorder?

1 A. No, that's not what I said.

2 Q. You said, "It would be inhumane to simply cut
3 off a patient because they would go into debilitating
4 and potentially life-threatening opioid withdrawal."

5 A. Right. So there is a distinction between
6 people who are physically dependent on opioids, and
7 that was the population I was referring to. And I
8 believe if you look at my statement, you'll see that
9 was the case. That is an overlapping population but a
10 distinct population from those who have DSM-5 opioid
11 use disorder.

12 Q. Is there anything on prescriptions in Ohio
13 that identify whether a patient has an opioid use
14 disorder?

15 MR. ARBITBLIT: Object to form.

16 THE WITNESS: Typically, the
17 prescription itself does not include the medical
18 condition for which the opioid is being prescribed.

19 BY MR. GISLESON:

20 Q. Well, is it necessary to do an official DSM-5
21 diagnosis to determine whether someone has opioid use
22 disorder?

23 A. In order to make a formal diagnosis of opioid
24 use disorder, it is best to use the DSM-5 criteria
25 because that's the professional criteria that is

1 considered the best standard today. But there are many
2 harbingers and signs and symptoms of an opioid problem
3 that might fall short of a DSM-5 diagnosable opioid use
4 disorder.

5 Q. Is special training necessary to diagnose
6 someone with opioid use disorder under the DSM-5?

7 MR. ARBITBLIT: Object to form.

8 THE WITNESS: I think special training
9 is always great, but, you know, if it walks like a duck
10 and talks like a duck, it's probably a duck.

11 BY MR. GISLESON:

12 Q. Do you believe the prescription should
13 identify patients who have opioid dependence or opioid
14 use disorder?

15 A. I think in many instances that would be a
16 HIPAA violation.

17 Q. So from your perspective, then, how is a
18 pharmacist to know that a patient has opioid dependence
19 or an opioid use disorder if it's not on the
20 prescription?

21 MR. ARBITBLIT: Object to form.

22 THE WITNESS: Yeah, thank you for asking
23 that. I think that's a really good and important
24 question. There are many actions that a pharmacist can
25 take in order to try to ferret out whether or not a

1 patient is struggling from the disease of addiction or
2 on their way to developing that disease. One of them
3 is to check the prescription drug monitoring database
4 to see whether or not there are red flags. Another of
5 them is to call the prescribing doctor and have a
6 discussion about any concerns that the pharmacist may
7 have regarding that prescription and the patient's
8 potential or manifestation of an opioid use problem.

9 Another is the appearance of the patient
10 themselves when they present to pick up their
11 prescription, as well as other demographic factors
12 regarding that individual. If they're paying with
13 cash, if they've traveled a far distance in order to
14 obtain the prescription. These are all well-known red
15 flags for misuse and diversion, which are a key part of
16 a pharmacist's role in drug utilization review.

17 BY MR. GISLESON:

18 Q. You don't have anything in your report, do
19 you, that identifies the extent to which any of the
20 chain pharmacy defendants reviewed OARRS reports as far
21 as dispensing opioid --

22 (Reporter clarification.)

23 Q. -- OARRS reports, O-A-A-R-S reports in
24 connection with dispensing opioid medications?

25 A. Well, what my report does contain is lots of

1 information on the fact that OARRS was never mandated
2 in any kind of complete way by pharmacy defendants,
3 although they could have done that very early on and
4 made a big difference in terms of the volume of pills
5 going out into the public.

6 And on top of that, there were so many
7 pressures and incentives on pharmacists themselves to
8 dispense quickly and to ignore the red flags that would
9 have made it -- that leads me to believe that the
10 checking of the OARRS database was far less than it
11 should have been.

12 Q. Move to strike as nonresponsive.

13 You also indicate that opioid overprescribing
14 after surgery is part of the general overprescribing
15 that happens. Is that because the prescribers are
16 including too many pills in the prescription?

17 A. Yes. It's well recognized that surgery can be
18 a gateway to opioid dependence, misuse, addiction, and
19 overdose.

20 Q. Does a prescriber exercise judgment in
21 deciding how many pills to prescribe for pain?

22 MR. ARBITBLIT: Objection to form.

23 THE WITNESS: As I've said before, the
24 ability to exercise judgment is impacted by many
25 things. The standard way that doctors learn is see

1 one, do one, teach one. When we're in our training and
2 we have an attending who has been misguided by the
3 industry to prescribe large volumes of pills after
4 surgery, we take that as what we should also be doing.

5 BY MR. GISLESON:

6 Q. And doctors have different reasons for why
7 they prescribe a certain number of pills following
8 surgery; is that correct?

9 MR. ARBITBLIT: Object to form. Vague.
10 Overbroad.

11 BY MR. GISLESON:

12 Q. Doctor, you can answer?

13 A. Can you please restate the question?

14 Q. Sure. Do you understand that different
15 doctors have different practices as to the number of
16 pills they prescribe for pain following a surgery?

17 A. I would generally disagree with that statement
18 as relates to the way opioids were prescribed beginning
19 in the late 1990s up through most of the last two
20 decades, especially given the electronic medical record
21 and the way in which that record often automatically
22 populated the number of pills based on this
23 misconception that the benefits are greater than they
24 really are, and the risks are less than they really
25 are.

1 Q. When you say, "automatically populated the
2 number of pills," what is the quantity to which you're
3 referring?

4 A. There are multiple studies now showing that
5 the way that opioids were prescribed in the early 2000s
6 until just several years ago, really, was to prescribe
7 far more pills than, for example, postsurgical patients
8 actually needed, and by reducing those number of pills,
9 discovering that the patients had no increase in their
10 postoperative pain, and the realization among the
11 medical community that the number of pills had been
12 excessive.

13 Q. Go to your book, please, page 96. You wrote
14 on page 96 in this first full paragraph, "Doctors are
15 more likely to prescribe opioids and other addictive
16 medications to patients on Medicaid, many of whom were
17 receiving disability payments."

18 Over what period of time, was that correct?

19 A. I'm not sure.

20 Q. Can you estimate?

21 A. No. I'd have to go back and look.

22 Q. You then write, "People receiving Medicaid are
23 prescribed painkillers at twice the rate of
24 non-Medicaid patients, and they die from prescription
25 overdoses at six times the rate."

1 Based on your research, do you have an
2 understanding as to why people receiving Medicaid are
3 prescribed painkillers at twice the rate of
4 non-Medicaid patients?

5 A. I believe it's because people on Medicaid have
6 less access to other non-medication treatments for
7 pain.

8 Q. So why, in your experience, would a doctor
9 prescribe more painkillers to Medicaid patients when
10 they lack access to other non-medication treatments?

11 MR. ARBITBLIT: Object to form.

12 THE WITNESS: I think doctors are trying
13 to help their patients. They want to do what's ever
14 within their power to help that patient, and if they've
15 been misguided into believing that opioids actually
16 work long-term for chronic pain and they don't have any
17 other resources, then they will use opioids.

18 BY MR. GISLESON:

19 Q. Is that reasonable in your view for doctors to
20 prescribe additional opioid medications to patients who
21 lacked access to non-medication treatments?

22 MR. ARBITBLIT: Object to form.

23 HE WITNESS: Again, if doctors have been
24 educated to believe, contrary to the evidence, that
25 opioids are safe and effective in the treatment of

1 chronic pain, then they are more likely to prescribe
2 opioids for those indications.

3 MR. GISLESON: Could you turn, please --
4 Matt Ladd, could you go to Tab 12, please?

5 MR. LADD: Don, do you want Tab 12
6 marked as Exhibit 1?

7 MR. ARBITBLIT: I just want to
8 interject, Counsel, that if you're referring to a
9 document that you've provided to the witness and to
10 Counsel, may she open an envelope with it? And
11 otherwise, we would object to using it.

12 MR. GISLESON: It would probably help.
13 Yeah, that's fine.

14 MR. ARBITBLIT: Dr. Lembke, do you have
15 a large -- like, a box of FedEx documents?

16 THE WITNESS: This one? I have three
17 different FedEx packages.

18 MR. ARBITBLIT: I think Mr. Giselson's
19 box is the largest.

20 THE WITNESS: Okay. Matthew Ladd,
21 Morgan, Lewis & Bockius.

22 MR. ARBITBLIT: That's his firm.

23 MR. GISLESON: I take that as a point of
24 pride.

25 MR. ARBITBLIT: I figured you would.

1 You're taking the lead; you should have the biggest
2 box.

3 THE WITNESS: I have to get a tool to
4 open this.

5 MR. CRAWFORD: John, should we go off
6 the record now?

7 MR. GISLESON: Yeah, that's fine.

8 THE VIDEOGRAPHER: We are going off the
9 record at 11:09.

10 (Recess taken 11:09 a.m. to 11:11 a.m.)

11 THE VIDEOGRAPHER: We are back on the
12 record. The time is 11:11. Please proceed.

13 (Exhibit 1 marked for identification.)

14 BY MR. GISLESON:

15 Q. Dr. Lembke, are you familiar with the "British
16 Medical Journal"?

17 A. Yes.

18 Q. And is that a peer-reviewed publication?

19 A. Yes.

20 Q. Is it well regarded in the medical community?

21 A. Yes.

22 Q. If we look at what has been marked as
23 Exhibit 1, is this a true and correct copy of an
24 article dated October 31, 2017, that you wrote entitled
25 "The Opioid Epidemic is a Symptom of Our Faltering

1 Healthcare System"?

2 A. I'm sorry, I don't know -- I have a big binder
3 here. I'm not sure. Is this --

4 Q. Yes, Tab 12.

5 A. Tab 12, okay.

6 Q. Which we've marked as Exhibit 1.

7 A. Can I just take a moment to look at it to make
8 sure that's what I wrote?

9 Q. Sure.

10 A. Okay, yes.

11 Q. Is this a true and correct copy of an article
12 you wrote for the "British Journal" entitled, "The
13 Opioid Epidemic is a Symptom of Our Healthcare System"?

14 A. Yes.

15 Q. This was published on October 31, 2017; is
16 that right?

17 A. Yes.

18 Q. As of this time, had you been retained by the
19 plaintiffs' lawyers in opioid litigation?

20 A. Just barely, yes.

21 Q. You wrote, "Much hullabaloo was made last week
22 of President Trump formally declaring the U.S. opioid
23 epidemic a public health emergency," correct?

24 A. Yes.

25 Q. And the U.S. opioid epidemic, that included

1 heroin, right, and fentanyl?

2 A. Yes, at that time.

3 Q. And if you skip down a paragraph you wrote,
4 "Not long after Trump's announcement, the critics piled
5 on, myself included. Most of the naysayers complained
6 that he had promised to declare the opioid epidemic a
7 national emergency, which would have granted immediate
8 access to Stafford funding, somewhere in the millions
9 rather than the paltry \$57,000 purported to be sitting
10 in the U.S. Public Health Emergency Fund," right?

11 A. Yes.

12 Q. You then write, "But whether it's the \$57,000
13 in the Public Health Emergency Fund, millions in the
14 Stafford Fund, or even billions from an appropriations
15 committee, an infusion of money to fight the epidemic
16 is going to have little impact. The opioid epidemic is
17 a system of our faltering healthcare system, and until
18 we see sweeping changes in the way healthcare is
19 delivered in this country, no amount of the throwing
20 money at the problem is going to make it go away."

21 That was your generally held belief as of the
22 time you wrote in article, correct?

23 A. Yes.

24 Q. You then write in the next paragraph, "This
25 opioid epidemic is first and foremost an epidemic of

1 overprescribing." And you would certainly agree with
2 that statement?

3 A. Yes, as I qualified earlier, it's the
4 prescribing plus the dispensing, but yes.

5 Q. In the next page you wrote, "Perverse
6 incentives inside of medicine drive overprescribing.
7 American doctors are paid by how many medical services
8 they provide, not by whether patients get better.
9 Services that involve writing a prescription, injecting
10 a medicine, or performing a surgical procedure, pay far
11 more than educating patients about healthy lifestyle
12 changes or providing them with non-opioid,
13 non-medication alternatives for pain, such as physical
14 therapy, psychotherapy, and massage, all of which have
15 been shown to work better than medications for chronic
16 pain conditions."

17 That was your generally held belief as of the
18 time that you wrote this article, correct?

19 A. Yes.

20 Q. And that's also based on the research as well
21 as your experience working in hospitals and with
22 patients; is that right?

23 A. Yes.

24 Q. You then wrote, "Doctors' salary and
25 professional advancement are tied by how well patients

1 rate them on patient satisfaction surveys. Doctors are
2 desperate to avoid bad ratings and will write a
3 prescription for an opioid even when it's not indicated
4 to avoid a dissatisfied customer."

5 What basis did you have for making those
6 statements?

7 A. I base that on the work -- the research that I
8 did for my book.

9 Q. You then write, "At the same time that doctors
10 are incentivized to prescribe opioid medications, they
11 are not trained or paid much to treat addiction."

12 Why do you believe that is?

13 A. Well, I believe that they're incentivized in
14 many different ways. They're incentivized through the
15 false and misleading messages on the part of
16 defendants, they're incentivized because of the
17 increasingly short amount of time they have to actually
18 see people. They're incentivized because of the
19 structure and the churn in the modern healthcare
20 system.

21 Q. When you write that doctors are not trained or
22 paid much to treat addiction, do you consider that a
23 failure of the American medical system?

24 A. Yes.

25 Q. You go on to write that "getting insurance

1 companies to pay for addiction treatment is still a
2 bureaucratic maze of carve-outs, prior authorizations,
3 and failed first criteria."

4 Is that still the case?

5 A. It's gotten better, but that's still the case,
6 yes.

7 Q. What did you mean by "bureaucratic maze of
8 carve-outs"?

9 A. Well, before the Mental Health Parity and
10 Addictions Equity Act --

11 (Reporter clarification.)

12 A. -- of 2008, followed by the Affordable Care
13 Act, it was difficult to get insurance coverage for
14 addiction treatment.

15 Q. And "prior authorizations" mean you need to
16 get prior approval from an insurance company before a
17 certain treatment?

18 A. That's right.

19 Q. And what is "fail first criteria"?

20 A. You have to try another treatment first before
21 you can be allowed to have the treatment that the
22 doctor is trying to give you.

23 Q. The next paragraph you wrote, "The opioid
24 epidemic will improve only when doctors get paid to get
25 patients better, including treating addiction."

1 Are doctors now getting paid to get patients
2 better?

3 A. I would say we're still not where we need to
4 be with that.

5 Q. You wrote that the "opioid epidemic is a
6 symptom of our faltering healthcare system and until we
7 see sweeping changes in the way healthcare is delivered
8 in this country, no amount of throwing money at the
9 problem is going to make it go away."

10 Have the sweeping changes in the way
11 healthcare is delivered in this country occurred?

12 A. No.

13 Q. If you can go, please, to Tab 13.

14 (Exhibit 2 marked for identification.)

15 MR. LADD: Tab 13 is being marked as
16 Lembke Exhibit 2.

17 BY MR. GISLESON:

18 Q. Thank you.

19 Dr. Lembke, I'd like to show you what has been
20 marked as Lembke Exhibit 2. Are you familiar with an
21 organization called Shatterproof?

22 A. Yes.

23 Q. And it was founded by a gentleman named Gary
24 Mendell?

25 A. Yes.

1 Q. And Shatterproof focuses on addiction issues;
2 is that right?

3 A. Yes.

4 Q. And you agreed to do a Q & A with Shatterproof
5 on America's Prescription Epidemic: How Did We Get
6 Here? Q & A with Anna Lembke," correct?

7 A. I don't specifically recall that, but.

8 Q. This is dated February 1, 2017.

9 A. Which exhibit are you looking at?

10 Q. Tab 13, which we marked as Exhibit 2.

11 A. This is the one entitled "America's Addiction
12 Epidemic: How Did We Get Here? Q & A" --

13 Q. Yes.

14 A. Okay.

15 Q. Do you recall submitting a written piece, one
16 or more, to a Shatterproof publication?

17 A. No, I don't recall submitting a written piece.
18 Might this have been an oral interview?

19 Q. Let me ask you this: The question on the
20 first page is, "Most of us are at least somewhat
21 familiar with alcoholism and street drug addiction, but
22 addiction to prescribed drugs, and opioids in
23 particular, seems a much newer epidemic. When and why
24 did this problem suddenly become so much larger?"

25 And then the answer is, "The current

1 prescription drug epidemic is first and foremost an
2 epidemic of overprescribing, not just of opioid
3 painkillers but of other controlled medications such as
4 sedatives (Xanax) and stimulants (Ritalin)."

5 Do you agree with the statement there?

6 MR. ARBITBLIT: I'm going to object to
7 the form of the question, and Dr. Lembke, if you
8 recognize this as something that you participated in
9 and gave that answer, you may answer the question. But
10 if you don't recognize it, I'm going to instruct you
11 not to answer something just because Counsel has read
12 it as something that purports to be your statement.

13 MR. GISLESON: Please don't coach the
14 witness, and that also was not my question.

15 BY MR. GISLESON:

16 Q. Dr. Lembke, my question is do you agree with
17 the statement that, "The current prescription drug
18 epidemic is first and foremost an epidemic of
19 overprescribing, not just of opioid painkiller but of
20 other controlled medications such as sedatives (Xanax)
21 and stimulants"?

22 A. I think the current opioid epidemic is
23 primarily a result of too many prescription opioids,
24 but certainly co-prescribing with other --

25 (Reporter clarification.)

1 A. -- medications like benzodiazapine and
2 stimulants is also of significant concern.

3 Q. And in your experience, based on your
4 research, have doctors been overprescribing sedatives
5 and stimulant too?

6 A. Yes.

7 Q. Next question, at the same page says, "What
8 factors caused this rapid and relatively recent rise in
9 the number of opioid pills prescribed by doctors?"

10 And this states, "The factors driving op --
11 strike that.

12 This states, "The factors driving
13 overprescribing are many and complex."

14 Do you agree with that statement?

15 A. Yes.

16 Q. This then says, "Here are some of the most
17 important," and this identifies "cultural narratives
18 that promote pills as quick fixes for pain."

19 Do you agree that that is a factor in
20 overprescribing?

21 A. Yes.

22 Q. It also says, "Medical disability scenarios
23 that hinge on patients taking pills and staying sick as
24 a way to secure an income."

25 Do you agree with that statement that that is

1 a factor driving overprescriptions?

2 A. I think you skipped the second one.

3 Q. Do you agree that "medical disability
4 scenarios that hinge on patients taking pills and
5 staying sick as a way to secure an income," are a
6 factor driving overprescriptions?

7 MR. ARBITBLIT: Object to form.

8 THE WITNESS: That is one of the factors
9 I've written about in my book.

10 BY MR. GISLESON:

11 Q. For how long has that been a factor driving
12 overprescriptions?

13 A. I don't know.

14 Q. Can you estimate in any way?

15 A. No.

16 Q. More than ten years?

17 A. I don't know.

18 Q. More than five years?

19 A. I don't know.

20 Q. Can you explain what is meant by "medical
21 disability scenarios that hinge on patients taking
22 pills and staying sick as a way to secure an income"?

23 A. As I talk about in my book, there are ways in
24 which our disability system has replaced welfare such
25 that individuals who are living in poverty, who also,

1 many of them, struggle with chronic pain, get a monthly
2 disability check based on their pain diagnosis. And
3 they're very reliant on that income in order to
4 survive.

5 And my point here is really that the
6 healthcare system is not taking care of these people
7 necessarily in the way that it should by forcing them
8 to use disability as a way to pay their bills.

9 Q. Do you agree that "a new medical bureaucracy
10 that is focused on the bottom line favoring pills,
11 procedures, and patient satisfaction over patients
12 getting well was a driving factor in overprescribing"?

13 A. Yes, and I think that the pharmacy defendants
14 know a lot about that since they used similar methods
15 to incentivize dispensing.

16 Q. Move to strike everything after "yes."

17 Do you have an understanding of what is meant
18 by "new medical bureaucracy that is focused on the
19 bottom line"?

20 A. As I said, you know, the majority of
21 healthcare providers now work as salaried employees in
22 large, integrated healthcare centers. They have
23 reduced autonomy. They are beholden to pain
24 guidelines, Joint Commission quality measures, there is
25 pressure to practice what is called evidence-based

1 medicine, and so they are very reliant on what it says
2 in the medical literature with, I might add, little
3 training on how to filter through that medical
4 literature for biases such as studies funded and
5 written by pharmaceutical opioid-defendant authors.

6 Q. It also states that "a driving factor in
7 overprescribing is disjointed medical care and
8 antiquated privacy laws that make it impossible for the
9 right hand to know what the left hand is prescribing."

10 Do you agree with that?

11 A. Yes.

12 Q. Can you explain what that means?

13 A. As I said before, many patients have different
14 doctors for different disease states, and until the
15 prescription drug monitoring database came along, it
16 was very difficult to know what other doctors were
17 prescribing, so difficult then to sort out, for
18 example, dangerous co-prescribing or duplicate
19 prescriptions.

20 And then HIPAA and 42 CFR, the privacy laws,
21 make it difficult at times for prescribers to
22 communicate with others around a patient's condition
23 because they need to, by law, respect the privacy of
24 the patient except in emergent situations.

25 Q. It then says, "Interwoven through all of this

1 is the complex interpersonal dynamic between doctors
2 and patients, riddled with mutual deception, wishful
3 thinking, wounded pride, and desperate attempts on both
4 sides to pretend that a doctor's only mission is to
5 heal and a patient's only mission to recover from
6 illness."

7 Do you agree with that statement?

8 A. I agree that it's a complex interpersonal
9 dynamic, yes.

10 Q. Is it likely you wrote that paragraph?

11 A. Yes.

12 Q. Next question is, "What has changed in
13 medicine that is driving physicians to prescribe so
14 much more than was once the case?"

15 And this states, "The biggest change in
16 medicine, which has contributed significantly to the
17 prescription drug epidemic, has been the mass exodus of
18 physicians out of physician-owned practices and into
19 integrated healthcare institutions.

20 "Prior to 2000, the majority of doctors worked
21 in physician-owned practices. Today, the majority of
22 doctors are salaried employees in large healthcare
23 conglomerates with billing quotas, patient satisfaction
24 surveys, and hospital quality measures, driving them to
25 provide a certain kind of care, even when that care is

1 against their better judgment and/or the health of the
2 patient."

3 Is that what you referred to earlier in your
4 testimony?

5 A. I'm sorry, could you say that again?

6 Q. Do you agree with that statement that I just
7 read?

8 A. Yes.

9 Q. And then the second-to-the-last line you
10 wrote, "But when it comes to prescribing pills as a
11 short-term quick fix for complex problems, top-down
12 medicine has been a disaster."

13 Do you agree with that statement?

14 A. Yes.

15 Q. On the next page in the paragraph before the
16 question, "What role has big pharma played in the rise
17 in prescription levels?" This states, "Over the course
18 of the past century, these changes in the way medicine
19 and society view pain have allowed for lessening the
20 burden of suffering for many people with pain."

21 Do you agree with that statement?

22 A. I think when that statement is referring to,
23 for example -- actually, if you don't mind, can I read
24 the preceding paragraphs? Because it seems like this
25 refers to -- the statement these changes refers to the

1 preceding paragraph, so I want to make sure I know what
2 it's referring to.

3 MR. GISLESON: We can go off the record
4 so you can do that. Why don't we go off the record so
5 she can read it.

6 THE VIDEOGRAPHER: Okay, thank you. We
7 are going off the record at 11:33.

8 (Recess taken 11:33 p.m. to 11:36 p.m.)

9 THE VIDEOGRAPHER: We are back on the
10 record the time is 11:36. Please proceed.

11 BY MR. GISLESON:

12 Q. This paragraph says, "Over the course of the
13 past century, these changes in the way medicine and
14 society view pain have allowed for a lessening of the
15 burden of suffering for many people with pain; however,
16 this altered perspective has also inadvertently
17 contributed to the opioid epidemic by encouraging
18 doctors to overprescribe opioids for chronic pain as a
19 way to make the elimination of all pain the goal of
20 medical treatment."

21 Do you agree with that statement?

22 A. Well, I wrote that statement. I think I would
23 qualify in this context whether or not I agree with it.

24 Q. You then wrote, "Emerging evidence suggests
25 that opioids are not effective when used long-term for

1 pain. They are very effective for short-term, i.e.,
2 1-3-day pain."

3 When you talk about emerging evidence, was
4 that evidence that was emerging in or about
5 February 2017?

6 A. No, in fact, there was plenty of evidence
7 already in existence that opioids are harmful, that
8 they're addictive. And there was no evidence that they
9 work in the treatment of chronic pain.

10 Q. You chose to use the phrase "emerging
11 evidence," right?

12 A. Well, that's what it says there. But it's
13 very clear that there is no evidence showing benefits
14 of opioids longer than about 12 weeks.

15 Q. The next page, please, under the question,
16 "What can stop the overprescribing of drugs in the
17 U.S.?" You wrote, "Unfortunately, the prescription
18 drug epidemic is likely to continue for the foreseeable
19 future unless we do more to target the unseen forces
20 driving the epidemic."

21 You go on to write, "What it will take to stop
22 the overprescribing of opioids and other pills is a
23 restructuring of medicine to a system which reimburses
24 doctors to provide the kind of treatment that actually
25 helps pain in the long-term."

1 You agree with that statement, correct?

2 A. Which statement are we talking about here?

3 Q. "What it will take to stop the overprescribing
4 of opioids and other pills is a restructuring of
5 medicine to a system which reimburses doctors to
6 provide the kind of treatment that actually helps pain
7 in the long-term."

8 A. That change is only part of the change that we
9 need to make to --

10 Q. Has that restructuring occurred?

11 MR. ARBITBLIT: Objection.

12 Argumentative. Interrupting the witness who is not
13 done with her answer.

14 BY MR. GISLESON:

15 Q. I'm sorry, Dr. Lembke. Continue.

16 A. I'm sorry, what was your question?

17 Q. I inadvertently cut you off. I apologize.

18 A. So what is in this document here is a partial
19 representation in truncated form of my opinion. Also,
20 importantly of note, you know, in the list of what
21 factors caused the opioid epidemic, you left off -- of
22 all the factors that were listed here, you left off the
23 one that says, "Corporations that are in cahoots
24 with organized medicine --

25 (Reporter clarification.)

1 A. "Corporations that are in cahoots with
2 organized medicine, misrepresenting medical science to
3 promote pill taking," and also, the section after the
4 question "What role has big pharma played in the rising
5 prescription levels," where I say, "big pharma, a
6 nickname for the multibillion-dollar pharmaceutical
7 industry has always been in the business of getting
8 doctors to prescribe more drugs, and they have used
9 every tactic at their disposal to do that."

10 So I think your questions have really
11 misrepresented this document and also my opinion,
12 because you left out important sections.

13 Q. Move to strike as nonresponsive.

14 If you look at the fourth page at the bottom,
15 the question is, "Can you explain why some individuals
16 may be dependent on a substance, including opioids,
17 whereas others are more than just dependent but rather
18 are addicted?"

19 You wrote, "The great and enduring mystery in
20 the field of addiction is why some people can use
21 addictive substances in moderation and never get
22 hooked, while others eventually progress to addictive
23 behavior. The risk is some combination of nature,
24 nurture, and neighborhood?"

25 And that still today is an accurate statement,

1 right?

2 A. Yes, as well as my further statement that the
3 greatest risk factor of all is simple access to the
4 drug.

5 Q. You then wrote, "The risk of developing
6 addiction increases fourfold if the individual has a
7 biological parent or grandparent with addiction.
8 Mental illness and early trauma increase the risk of
9 addiction. Growing up in an environment in which
10 maladaptive substance use is modeled and condoned is
11 also a risk factor. Perhaps the greatest risk factor
12 of all is simple access. If alcohol and drugs are
13 readily available, the individual is at greater risk to
14 use them and become addicted to them."

15 And all of that was that true when you wrote
16 it in 2017, and it remains true?

17 A. Yes.

18 Q. Was that true before 2017 as well?

19 A. Are you saying was that my opinion before
20 2017?

21 Q. Yes.

22 A. Yes. I mean, there was a point in my career
23 when I didn't understand much about addiction myself,
24 so I could only really form these opinions after I had
25 done research and had the clinical experience and

1 knowledge.

2 Q. And then on that same page under the question,
3 "Tell us what one can expect about addiction recovery
4 success rates. Is the forecast rosy or dim?
5 Improving?"

6 And you wrote, "It's a myth that people with
7 addiction don't get better. About 50 percent of people
8 who get addiction treatment get into recovery, response
9 rates that are on par with those who get depression --
10 treatment. Many recover without any professional
11 treatment at all. Those who actively participate in AA
12 and other 12-step groups have outcomes on par with
13 those who get professionally mediated treatment, like
14 cognitive behavioral therapy. AA may even be better
15 than CBT long-term, for those who have a goal of
16 abstinence."

17 Do you still agree with that statement?

18 A. Yes.

19 Q. And is that currently the case, that it's a
20 myth that people with addiction don't get better?

21 MR. ARBITBLIT: Objection to form.

22 THE WITNESS: I think that the general
23 public as well as healthcare providers lack knowledge
24 about addiction and addiction treatment, and there is
25 kind of a pessimistic sense out there that people with

1 addiction will always be addicted, when in fact, people
2 with addiction are average people across all walks of
3 life, and that with treatment people can get into
4 recovery.

5 BY MR. GISLESON:

6 Q. Is it still the case that about 50 percent of
7 people who get addiction treatment get into recovery?

8 A. That is based on an article by McLellan, et
9 al., comparing the outcomes in patients who get
10 treatment for addiction to patients who get treatment
11 for other chronic illnesses with a behavioral component
12 like Type 2 diabetes showing that in treatment people
13 with addiction look similar to people with other
14 chronic illnesses with behavioral components, that the
15 response rate across the board, that's referring to a
16 different article by Humphries, et al., showing that on
17 average response rates are about 50 percent.

18 MR. GISLESON: Okay, why don't we take a
19 break for lunch. Or breakfast. Don, how much time do
20 you want to take, 20 minutes? Half an hour?

21 MR. ARBITBLIT: That's up to you.

22 MR. GISLESON: Dr. Lembke, what's best
23 for you?

24 THE WITNESS: How many hours are we in
25 now?

1 THE VIDEOGRAPHER: Should with we go off
2 the record and then discuss?

3 MR. GISLESON: Yes, please.

4 THE VIDEOGRAPHER: We are going off the
5 record at 11:45.

6 (Recess taken 11:45 a.m. to 12:14 p.m.)

7 THE VIDEOGRAPHER: We are back on the
8 record. The time is 12:14. Please proceed.

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AFTERNOON SESSION

11:27 A.M. EDT 12:14 p.m. PDT

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EXAMINATION RESUMED

BY MR. GISLESON:

Q. Dr. Lembke, have you ever practiced pharmacy?

A. If by that you mean am I a pharmacist, no.

Q. Did you ever attend pharmacy school?

A. No.

Q. Do you have a degree in pharmacy?

A. No.

Q. Have you ever trained as a pharmacy technician?

A. No.

Q. Have you ever worked in a pharmacy?

A. No.

Q. Have you ever dispensed opioid medications?

A. No.

Q. Have you taken any classes with pharmacists?

A. Not that I'm aware of.

Q. Have you ever trained pharmacists in the dispensing of opioid medications?

A. It's possible that in many talks I've given there were pharmacists in the audience.

Q. Have you ever trained pharmacists on the

1 dispensing of opioid medications?

2 A. Again, I've given many talks on the safety and
3 efficacy of opioids and on the problem of increased
4 supply and exposure as a major risk factor for
5 addiction to opioids, and in those talks, some of which
6 were CME talks and some of which were not, it's very
7 possible that there were pharmacists in the audience.

8 Q. Have you ever given a talk to pharmacists in
9 which you were advising the pharmacists specifically
10 what steps they should follow before dispensing an
11 opioid medication?

12 A. No.

13 Q. Have you ever worked for the Drug Enforcement
14 Administration?

15 A. No.

16 Q. Have you ever worked for a state Board of
17 Pharmacy?

18 A. No.

19 Q. Pharmacists are regulated by a state Board of
20 Pharmacy; is that right?

21 A. Yes.

22 Q. The Board of Medicine does not regulate
23 pharmacists; is that correct?

24 A. That's correct.

25 Q. Before writing the report that we've looked at

1 today, have you ever held yourself out as an expert in
2 the practice of pharmacy?

3 A. I am an expert in the practice of detecting
4 misuse, diversion, addiction. I do have expertise in
5 the Controlled Substances Act and scheduled drugs, and
6 I do have expertise in terms of my collaborative
7 responsibility in relationship with pharmacists with
8 whom I have multiple encounters on any given clinic
9 day. I also have expertise in the prescription drug
10 monitoring database which is a tool that pharmacists
11 use.

12 Q. I'll ask again. Have you ever specifically
13 held yourself out as an expert in the practice of
14 pharmacy before you wrote this expert report?

15 MR. ARBITBLIT: Object to form.

16 THE WITNESS: Again, I do think I have
17 expertise in terms of pharmacy practices, vis-a-vis the
18 opioid epidemic, and I have held myself out as such.

19 BY MR. GISLESON:

20 Q. Have you ever given a talk in which you told
21 the attendees that you were an expert in the practice
22 of pharmacies by pharmacists?

23 A. No.

24 Q. Before issuing this report, had you ever
25 evaluated whether a pharmacist complied with the duties

1 applicable to a pharmacist in dispensing an opioid
2 medication pursuant to a prescription?

3 A. Yes.

4 Q. When?

5 A. As part of the research for my book, I
6 interviewed multiple stakeholders and representatives
7 within medicine, including pharmacists, and had
8 discussions around their experiences with opioid misuse
9 and diversion.

10 Q. Other than speaking with pharmacists, have you
11 taken any classes on what a pharmacist should do before
12 dispensing an opioid medication?

13 A. Well, pharmacists and doctors have similar
14 responsibilities when it comes to detecting and
15 allowing access to controlled substances, so in that
16 sense, there is an overlapping education.

17 Q. Have you taken any classes that were specific
18 to the steps that a pharmacist must take before
19 dispensing an opioid medication?

20 MR. ARBITBLIT: Object to form.

21 THE WITNESS: My answer to that would be
22 I've actually taught on the subject of what steps
23 pharmacists should take before dispensing an opioid
24 medication. It's part of my -- it's part of my broader
25 expertise in addiction medicine.

1 BY MR. GISLESON:

2 Q. And to whom did you teach that issue?

3 A. I've given multiple talks within Stanford and
4 outside regarding how to use the prescription drug
5 monitoring database, what constitutes red flags for
6 opioid misuse and diversion. I have talked outside of
7 Stanford, if I didn't say that already, on the same and
8 I've also published articles on red flags for misuse
9 and diversion of opioids. Beyond my book, that is.

10 Q. What training did pharmacists in Ohio receive
11 in pharmacy school concerning their corresponding
12 responsibility?

13 A. I assume that pharmacists in Ohio received the
14 same training that pharmacists received nationally.

15 Q. Do you know for a fact what training they
16 received on their corresponding responsibility while in
17 pharmacy school?

18 A. I don't have specific knowledge about pharmacy
19 schools in Ohio, but I have no evidence to suggest that
20 it's any different from pharmacy training nationally.

21 Q. And what do you understand pharmacy training
22 is nationally concerning a pharmacist's corresponding
23 responsibility?

24 A. A pharmacist -- one of the pillars of drug
25 utilization review is to detect for misuse and

1 diversion of controlled substances. It's a major
2 aspect of a pharmacist's job. They are taught to look
3 out for red flags, and there is a long list of red
4 flags that pharmacists are trained on.

5 Q. Do you know what courses pharmacists take in
6 pharmacy school?

7 A. As I said, pharmacists are trained on
8 detecting misuse and diversion, identifying red flags
9 and doing what is in their corresponding responsibility
10 as outlined by the Controlled Substances Act to prevent
11 misuse and diversion.

12 Q. Did you do any research on the practice of
13 pharmacy in connection with the report that you've
14 given in this case?

15 A. Yes.

16 Q. What was the research?

17 A. I've reviewed a number of articles on the
18 nature of a pharmacist's job, I've reviewed the
19 regulations and the policies that the defendants put in
20 place regarding the detection of red flags and a
21 pharmacist's role in terms of misuse and diversion.
22 I've researched lay press articles on whether or not
23 pharmacists actually have the time and ability to do
24 their due diligence around detecting and preventing red
25 flags.

1 Q. Anything else?

2 A. Can you repeat the question?

3 Q. What resource did you do on the practice of
4 pharmacy in connection with the report that you've
5 given in this case?

6 A. Can I review my report for a moment? I have
7 looked at the medical literature on pharmacists and
8 pharmacy dispensing. I have looked at DEA decisions on
9 enforcement for pharmacies. I have looked at documents
10 from the National Association of Chain Drugstores, and
11 again, I have looked at the defendants' policies and
12 procedures over time regarding red flags, PDMP, and
13 dispensing.

14 Q. Where in your report does it identify the
15 research that you did relating to the practice of
16 pharmacy?

17 A. On page 103 at romanette 15, I discuss the
18 research on the dangers of opioid and benzodiazapine
19 prescribing and describe that as early as 2002 there
20 were known risks combining opioids and benzodiazepines
21 and that it is the responsibility of pharmacies to be
22 aware of dangers of co-prescribing that are described
23 in the medical literature and incorporate those into
24 their practices. That literature is described on
25 page 103, 104 of my report onto page 105, again, on

1 page 107.

2 Q. That's research generally relating to
3 co-prescribing. I'm asking what research generally you
4 did on the practice of pharmacy by licensed
5 pharmacists.

6 A. In addition to the many documents I reviewed
7 provided by the defendants in discovery, I also cite a
8 number of different articles in my report at different
9 places regarding pharmacy practice. For example, on
10 page -- for example, on page 124, I cite an article by
11 Marilyn Bullock called, "The Evolution of the PDMP" in
12 "Pharmacy Times." And she states, I quote, "mandating
13 that all prescribers and pharmacists enroll in PDMPs
14 and requiring more frequent data reports would create a
15 more unified fight against drug diversion. Because
16 pharmacists verify countless controlled substances
17 every day, they can greatly affect drug diversion.
18 Reviewing the PDMP prior to dispensing could become a
19 part of the regular workflow regardless of a
20 pharmacist's respected state mandates PDMP query and
21 reporting. PDMP may not be the sole solution to the
22 opioid crisis or other drug diversion, but they
23 represent progress in combatting the epidemic."

24 Also, again, as stated before in multiple
25 places in my report, I look at articles discussing the

1 conditions in which pharmacists work, including
2 specifically an article on page 151 from the University
3 of Cincinnati. This article describes a study of Rite
4 Aid pharmacy in which they report that Rite Aid
5 pharmacists typically spent far less than 15 minutes on
6 each prescription. In fact, according to a University
7 of Cincinnati study of Rite Aid's prescription fill
8 rates in 2011, Rite Aid pharmacists spent on average
9 3.22 minutes on any given prescription or 18.66 scripts
10 per hour. This fill rate is a recipe for prescribing
11 errors, providing inadequate time to investigate red
12 flags or fulfill the corresponding responsibility to
13 dispense controlled substances only for legitimate
14 medical purposes.

15 Q. Can you identify any other articles you read
16 in connection with your report that relate to the
17 practice of pharmacy?

18 A. Yes, there are other articles in my report.

19 Q. How much time did you spend researching
20 articles relating to the practice of pharmacy?

21 A. I don't have a specific number of hours.

22 Q. Can you estimate it in any way?

23 A. Many hours.

24 Q. And all the research that you described in
25 your report on the practice of pharmacy is research

1 that you performed after the plaintiffs' lawyers asked
2 you to express an opinion about the chain pharmacy
3 defendants; is that right?

4 A. The majority, yes.

5 Q. Have you published any peer-review articles
6 that address the practice of pharmacy?

7 A. Well, I have published -- I have published
8 articles on red flags, how to detect them, what
9 constitutes a red flag in terms of opioid prescribing.

10 Q. Have you published any peer-review articles on
11 any other subject?

12 A. I've published --

13 MR. ARBITBLIT: Object to form.

14 THE WITNESS: -- widely on the opioid
15 epidemic which is pertain to pharmacy practice.

16 BY MR. GISLESON:

17 Q. Have you published any peer-reviewed articles
18 specific to the practice of licensed pharmacists in
19 dispensing opioid medications?

20 A. I do believe that much of my writing is
21 relevant to the practice of pharmacy.

22 Q. I'm not asking about relevance. Have you
23 published any peer-reviewed articles specific to the
24 practice of licensed pharmacists in dispensing opioid
25 medications?

1 MR. ARBITBLIT: Object to form.

2 THE WITNESS: My publications are
3 directed broadly to various stakeholders inside of
4 medicine, and that would include pharmacists.

5 BY MR. GISLESON:

6 Q. Did you review any of the prescriptions in
7 this case to determine whether they contained any red
8 flags?

9 A. By that, do you mean the specific notes
10 regarding specific prescriptions?

11 Q. The specific prescription itself.

12 A. No. Those are not --

13 Q. Have you reviewed any prescription data?

14 MR. ARBITBLIT: Object to form.

15 THE WITNESS: What do you mean by
16 "prescription data"?

17 BY MR. GISLESON:

18 Q. Data that is maintained by one of the chain
19 pharmacy defendants that identifies opioid medications
20 that have been dispensed by that pharmacy defendant?

21 A. Yes.

22 Q. What data did you review?

23 A. So if you give me a moment to find it, please.

24 Page 84 of my report contains a table with specific
25 data on Walgreens' income due to the sale of OxyContin

1 importantly showing that their annualized income in
2 2010 was roughly the same as their annualized income in
3 2017.

4 Q. Anything else -- strike that.

5 Any other pharmacy data relating to
6 prescriptions for opioid medications that have been
7 filled?

8 A. Again, on page 92, there is a table showing
9 the average prescription size and number of OxyContin
10 prescriptions written for Walgreens pharmacies.

11 Q. Can you tell from that data whether the
12 prescriptions were issued for legitimate medical
13 purpose?

14 MR. ARBITBLIT: Object to form.

15 THE WITNESS: Again, I'm reluctant to
16 respond to your use of the term "legitimate medical
17 purpose" because I don't think we're talking about that
18 in the same way.

19 BY MR. GISLESON:

20 Q. Any other prescription data by one of the
21 chain pharmacy defendants that you've reviewed?

22 A. Please give me a moment. And by "data," are
23 you referring to numbers?

24 Q. Correct.

25 A. Uh-huh. On page 101, there was a survey

1 performed by the National Association of Boards of
2 Pharmacies showing that 83 percent of pharmacies
3 surveyed believed that distractions due to performance
4 metrics or measured wait times contributed to
5 dispensing errors, and that 49 percent felt specific
6 time measurements were a significant contributing
7 factor which could reduce time for drug utilization
8 review and ultimately result in unsafe prescribing.

9 Q. Did you ask plaintiffs' Counsel to give you
10 access to any pharmacy defendant's data to show the
11 specific number of Schedule 2 opioid medication
12 prescriptions that that pharmacy filled?

13 MR. ARBITBLIT: I'll object and instruct
14 not to answer with respect to discussions with Counsel.
15 BY MR. GISLESON:

16 Q. Did you request the opportunity to review any
17 chain pharmacy defendants' prescription data to
18 identify the average duration of any opioid
19 prescription?

20 MR. ARBITBLIT: Same instruction.

21 MR. GISLESON: You instruct her not to
22 answer?

23 MR. ARBITBLIT: Yes.

24 BY MR. GISLESON:

25 Q. Have you written any articles that

1 specifically analyze a pharmacist's corresponding
2 responsibility when dispensing an opioid medication?

3 A. No.

4 Q. Have you written any articles that
5 specifically addresses the operation of a pharmacy as
6 applied to prescription opioid medications?

7 A. I do address pharmacies in my book "Drug
8 Dealer M.D.," although briefly.

9 Q. And what you say in your book on pharmacies
10 there was that Internet pharmacies dispensed a very
11 high percentage of controlled substances, correct?

12 A. Well, relative to their total prescribing,
13 yes, but in terms of absolute numbers of prescriptions,
14 those numbers are far higher for the brick-and-mortar
15 pharmacies.

16 Q. And in terms of the percentage of controlled
17 versus non-controlled substances, the brick-and-mortar
18 pharmacies prescribe a much lower percentage of
19 controlled related to non-controlled substances,
20 correct?

21 A. I believe that is true.

22 Q. Have you written any articles about the
23 pharmacy supply chain management?

24 A. I have published on that.

25 Q. What have you published?

1 A. I believe in my book I do address -- well, I
2 do address in my book the importance of access as a
3 risk factor and the widespread availability across the
4 country to opioids as a major risk factor for opioid
5 addiction and overdose deaths. And I also have
6 published in the --

7 (Reporter clarification.)

8 A. -- Journal of the American Medical Association
9 an analysis of a Medicare 2013 database to look at
10 opioid prescribing. I have two publications in JAMA on
11 that topic using the Medicare database with the
12 explicit emphasis in those articles of Medicare being a
13 nationally representative sample demonstrating that
14 these effects are widespread through every corner of
15 the United States.

16 Q. Have you written any articles that address the
17 process by which opioid medications specifically go
18 from a manufacturer to a dispensing pharmacy?

19 A. I have not written on the nuts and bolts of
20 that process, no.

21 Q. How many articles, approximately, have you
22 published on the opioid crisis?

23 A. It would depend on whether we're talking about
24 peer-reviewed articles or lay press articles.

25 Q. Both.

1 A. I could get my CV out and count if you'd like.

2 Q. Greater than how many?

3 A. Why don't I get my CV out and count.

4 Q. Let me ask you this: So whatever articles
5 you've written, are in your CV, right?

6 A. Yes. Actually, so for example, you proffered
7 today a document that you stated that I wrote but I
8 think that may, in fact, be the result of an oral
9 interview which was then transcribed into written form.
10 I'm not sure because I don't explicitly remember that
11 document or that interview.

12 Q. In how many published articles, whether
13 peer-reviewed or not prior to writing your expert
14 report in this case have you attributed the opioid, in
15 your words, epidemic to the chain pharmacy defendants?

16 A. So prior to me being retained in this case, I
17 had written and taught and spoken publicly on the
18 involvement of the opioid pharmaceutical industry
19 without necessarily specifically calling out the
20 pharmacies.

21 Q. Can you identify even a single article that
22 you've written in which you call out the pharmacies as
23 being the cause or one of the causes of the opioid
24 epidemic?

25 A. Except for that brief mention in my book that

1 you and I just spoke of, no.

2 Q. Have you read any peer-reviewed articles that
3 address -- strike that.

4 Have you read any peer-reviewed articles that
5 assign blame for the opioid epidemic on the chain
6 pharmacy defendants?

7 A. I have read and also included in my report
8 multiple definitive articles which have blamed the
9 opioid pharmaceutical industry broadly for the
10 epidemic, and I take that to include pharmacies.

11 Q. Can you identify even a single peer-reviewed
12 article that assigns blame for the opioid epidemic
13 specifically to the chain pharmacy defendants in this
14 case?

15 MR. ARBITBLIT: Object to form.

16 THE WITNESS: As I sit here today, I am
17 not recalling an article that specifically names the
18 pharmacy defendants in the case today, but I've already
19 mentioned to you at least one article that is in my
20 report regarding what pharmacies could have and should
21 have done to prevent the opioid epidemic.

22 BY MR. GISLESON:

23 Q. What is a community pharmacist?

24 A. I assume that that means somebody who works in
25 a relatively smallish community and is identified in

1 that community as somebody who is a pharmacist.

2 Q. Walk through the process from intake to
3 dispensing that in your view a pharmacist working for
4 one of the -- strike that.

5 Walk me through the process from intake to
6 dispensing that in your view a reasonable pharmacist in
7 Ohio must follow before dispensing an opioid medication
8 pursuant to a prescription.

9 MR. ARBITBLIT: Object to form.

10 THE WITNESS: What do you mean by
11 "reasonable"?

12 BY MR. GISLESON:

13 Q. Walk me through the process from intake to
14 dispensing that under applicable Ohio law and
15 regulations a pharmacist must follow before dispensing
16 an opioid medication pursuant to prescription.

17 MR. ARBITBLIT: Object to form. Calls
18 for a legal conclusion.

19 BY MR. GISLESON:

20 Q. Let me rephrase the question. Do you have an
21 understanding as to the process that a pharmacist in
22 Ohio must follow from intake to dispensing when filling
23 a prescription for an opioid medication?

24 MR. ARBITBLIT: Object to form.

25 THE WITNESS: Yes.

1 MR. ARBITBLIT: You can answer. Object
2 to form.

3 BY MR. GISLESON:

4 Q. What's the process?

5 A. The pharmacist must identify that the right
6 person is getting the right drug for the right amount
7 and duration and the correct medical indication from a
8 prescriber with whom they have a legitimate
9 relationship in the course of the normal care of that
10 prescriber. And in addition, the pharmacist must do
11 his or her due diligence to make sure that any
12 prescription for a controlled substance is not being
13 misused or diverted in some way.

14 Q. What is the process that the Rite Aid
15 pharmacists in Ohio specifically followed when filling
16 an opioid medication prescription?

17 MR. ARBITBLIT: Object to form. Vague.
18 Overbroad.

19 THE WITNESS: So it would really depend
20 on the time that you're talking about since Rite Aid's
21 policies changed over time.

22 BY MR. GISLESON:

23 Q. I'm asking for the detailed steps from intake
24 until it goes out the door. What do the Rite Aid
25 pharmacists do?

1 MR. ARBITBLIT: Object to form. Vague.
2 Overbroad.

3 BY MR. GISLESON:

4 Q. You can answer.

5 A. The pharmacist looks at the prescription from
6 the provider. The pharmacist assures themselves that
7 the person presenting the prescription is either the
8 patient, him or herself or some responsible party, who
9 will get that prescription to the patient. The
10 pharmacist looks at the amount, the duration.

11 The pharmacist hopefully looks at prescribing
12 history, not just for that individual patient but also
13 the prescriber, to see whether or not there are any red
14 flags there. The pharmacist looks for drug-drug
15 interactions, and then the pharmacist looks carefully
16 for red flags to determine whether or not there are any
17 concerns for dangerous polypharmacy, misuse, diversion,
18 allergies.

19 Once all of that is completed, then the
20 pharmacist, using the information that they have, needs
21 to exercise their professional judgment as to whether
22 or not the medication can and should be dispensed.

23 If there are red flags, then the pharmacist is
24 obligated to investigate those red flags, and if the
25 investigation proves that there is good suspicion for

1 misuse, diversion, not being dispensed for legitimate
2 medical purpose or not being dispensed in the usual --
3 in the usual patient-provider relationship, then that
4 individual should not dispense the medication.

5 If they determine after investigating the red
6 flag that in fact there is good cause to dispense
7 medication, then they can dispense the medication. As
8 they're dispensing the medication to the patient, they
9 play a very important advisory role, making sure that
10 the patient, him or herself, is educated about the
11 medication, what its purposes is, how to take it, any
12 side effects to be worried about and any other
13 questions that they may have.

14 Q. You said that the pharmacist exercises
15 professional judgment whether to dispense an opioid
16 medication. What do you mean by "professional
17 judgment"?

18 A. Well, those were not my exact words. I
19 believe my exact words were that they would exercise
20 their professional judgment based on the data and
21 information that they have. So if --

22 Q. You said --

23 MR. ARBITBLIT: You're interrupting
24 Counsel. She's answering a question, and you're
25 interrupting her.

1 BY MR. GISLESON:

2 Q. Proceed, please.

3 A. So if that pharmacist has access to good
4 information, then they can exercise their professional
5 judgment. If they're disempowered either by not having
6 access or not having time or not being encouraged to do
7 their due diligence, then they will not be exercising
8 their clinical good judgment.

9 Q. What did you mean when you said that the
10 pharmacist exercises professional judgment whether or
11 not the medication can and should be dispensed?

12 MR. ARBITBLIT: Object to form.

13 THE WITNESS: Well, the process of
14 exercising good judgment means taking into account all
15 of the information that you have access to, along with
16 your commonsense and your other decision-making
17 abilities to come to a conclusion. But that can't be
18 seen in isolation. That must be seen in the broader
19 context of what other pressures are on that individual.
20 And in this case in particular, there are and have been
21 pressures on pharmacists that have superseded their
22 ability to exercise their judgment at all regarding
23 dispensing opioids. And I'm happy to go to examples in
24 my report if that would be helpful.
25

1 BY MR. GISLESON:

2 Q. What did you do as part of your report
3 preparation to determine whether Rite Aid's pharmacists
4 exercised good judgment in deciding whether to fill
5 opioid prescriptions?

6 A. I looked at the way that Rite Aid pharmacists
7 were educated and what kind of information they had
8 access to. And I determined that Rite Aid corporate
9 leadership collaborated with opioid manufacturers and
10 propagated some of the same myths around opioid
11 prescribing that were generally rolled out to
12 prescribers, also to pharmacists.

13 I looked at Rite Aid's policies regarding
14 pressures on dispensing -- give me a moment here. And
15 found that issues related to incentivizing, dispensing,
16 understaffing, and poor enforcement contributed to
17 pressure on pharmacists to dispense opioids, even in
18 the presence of red flags. I looked at DEA claims of
19 violations of the Controlled Substances Act that stated
20 that Rite Aid knowingly filled prescriptions for
21 controlled substances that were not issued for a
22 legitimate medical purpose pursuant to a valid
23 physician-patient relationship.

24 Again, I looked at things like the store bonus
25 program where Rite Aid staff pharmacists were eligible

1 for a bonus based on 80 percent from store profits and
2 20 percent from customer satisfaction from controlled
3 substance prescriptions that were included in that
4 bonus calculation. Again, Rite Aid's 2009 prescription
5 incentive bonus program designed to, quote, "reward our
6 pharmacy and front and associates for increasing their
7 overall prescription business," unquote, which
8 encouraged pharmacists to contact patients to pick up
9 their pain medicine as a way to increase prescription
10 sales.

11 Q. Did you analyze the exercised professional
12 judgment by Rite Aid pharmacists at any specific store
13 in Lake or Trumbull County?

14 A. I did analyze a partnership between Rite Aid
15 and -- just one moment, please -- and the American --

16 Q. I'm sorry, continue.

17 A. I did analyze a collaboration between Rite Aid
18 and the American Pain Foundation on a brochure called
19 "The Pain Relief Guide," which was promoted on radio
20 stations in Ohio, including Cleveland, Ohio.

21 Q. Do you know the names of any of the
22 pharmacists who work for the chain pharmacy defendants
23 in Lake or Trumbull Counties?

24 A. One moment, please. I don't believe so, no.

25 Q. Do you know how many pharmacists each of the

1 pharmacy defendants has in Trumbull and Lake Counties?

2 A. No.

3 Q. Do you know what the average duration was for
4 prescriptions that were filled for controlled
5 substances by any of the chain pharmacy defendants?

6 A. No.

7 Q. What was the process that the chain -- strike
8 that.

9 You understand that corresponding
10 responsibility applies only to the pharmacist, right?

11 MR. ARBITBLIT: Objection. Misleading.

12 THE WITNESS: I would disagree with
13 that. I think the DEA, some of the DEA enforcement
14 rulings have made it very clear that the corresponding
15 responsibility applies not just to the pharmacists but
16 also to the pharmacies.

17 BY MR. GISLESON:

18 Q. You understand that it's the pharmacist who
19 exercises the judgment whether to dispense an opioid
20 medication, correct?

21 MR. ARBITBLIT: Object to form.

22 THE WITNESS: Again, that judgment
23 cannot be adequately exercised in an environment where
24 pharmacists are not given the information or the
25 support or the time or the incentives to exercise their

1 judgment.

2 BY MR. GISLESON:

3 Q. Do you understand that it's the pharmacist who
4 exercises the judgment whether to dispense an opioid
5 medication, correct?

6 MR. ARBITBLIT: Object to form. Asked
7 and answered.

8 BY MR. GISLESON:

9 Q. Can you answer the question, Dr. Lembke?

10 A. One moment. Okay. I would just refer to my
11 report on page 142 where Walgreens pharmacist Robert
12 Yaeger wrote in an email to inform Walgreens that store
13 managers had challenged his attempts to override his
14 refusal to fill a prescription for a C2 medication, and
15 that such conduct was part of a larger problem.
16 Mr. Yaeger talked about -- so basically Mr. Yaeger
17 refused to fill a prescription for an opioid following
18 Walgreens' good faith dispensing policies and the
19 reason that -- and when he did that, two of the
20 managers challenged him. He described their behavior
21 as, quote, "extremely intimidating and persuasive," end
22 quote. He said that this was not an isolated event,
23 that this was happening across multiple Walgreens
24 pharmacies. He described --

25 Q. Are you able to evaluate the exercise of any

1 individual -- strike that.

2 Are you able to identify how any individual
3 pharmacist went about the process of exercising
4 professional judgment in filling a prescription for an
5 opioid medication?

6 MR. ARBITBLIT: Object to form.

7 THE WITNESS: I mean that's like asking
8 me do I know how people exercise judgment.

9 BY MR. GISLESON:

10 Q. Correct. Are you able to identify how any
11 individual pharmacist in Lake and Trumbull Counties for
12 any of the chain pharmacies in fact went about the
13 practice of exercising professional judgment when
14 filling a prescription for an opioid medication?

15 MR. ARBITBLIT: Object to form.

16 THE WITNESS: Yes. So as I state in my
17 report, there were -- these policies were national
18 policies and the systemic problems that existed in
19 defendants' pharmacies across the nation including Lake
20 and Trumbull County essentially disempowered
21 pharmacists from exercising their clinical judgment.

22 BY MR. GISLESON:

23 Q. How do know that any pharmacist for a chain
24 pharmacy in Lake and Trumbull County, in fact, was
25 disempowered from exercising clinical judgment?

1 A. I haven't seen any evidence to the contrary.
2 I would be happy to evaluate that if you have evidence
3 to the contrary, but again, these were national
4 policies. I have no reason to believe that Lake and
5 Trumbull Counties are an exception in any way.

6 Q. How do we test your theory that pharmacists
7 for the chain defendants in Lake and Trumbull County
8 were disempowered from exercising clinical judgment?

9 MR. ARBITBLIT: Object to form.

10 THE WITNESS: I don't think it's a
11 theory that I have. I think there is plenty of
12 evidence that when you have 3.22 minutes to fill
13 a prescription, it's going to be very difficult to do
14 your due diligence to make sure that you explore red
15 flags.

16 BY MR. GISLESON:

17 Q. Did you do any analysis of the time to fill
18 prescriptions for any of the chain defendants in Lake
19 or Trumbull Counties?

20 A. No, but the University of Cincinnati did.
21 They studied Rite Aid's prescription fill rates in
22 2011.

23 Q. And that involves fill rates for all
24 medications, not just controlled substances, correct?

25 A. That's correct.

1 Q. And how can we test whether time pressures in
2 fact caused one of the pharmacists for a chain pharmacy
3 to dispense an opioid medication that did not have a
4 legitimate medical purpose?

5 MR. ARBITBLIT: Object to form.

6 THE WITNESS: Could you rephrase the
7 question? I'm not really sure I understood.

8 BY MR. GISLESON:

9 Q. You claim that time pressures caused
10 pharmacists in Lake and Trumbull County to dispense
11 opioid medications that should not have been dispensed,
12 right?

13 A. That's not the only factor, but yes, that's
14 one the factors.

15 Q. How do we determine the extent to which that
16 occurred?

17 MR. ARBITBLIT: Object to form.

18 BY MR. GISLESON:

19 Q. Stated differently, what did you do to
20 determine whether time pressures, in fact, caused any
21 of the pharmacists for the chain defendants to dispense
22 an opioid medication that should not have been
23 dispensed?

24 A. Again, I think that the trends that are
25 documented to be occurring nationally at defendants'

1 pharmacies would also have been occurring at the
2 pharmacies in Lake and Trumbull County. I'd just refer
3 you to page 102 of my report where I cite a number of
4 different articles saying "pharmacy staffing levels can
5 threaten patients' lives" in the journal drug topics.
6 Also, pharmacists' workload contributes to errors in
7 the "Science Daily." Those are footnotes 508 and 509.

8 Q. What did you do, though, to determine whether
9 those findings, in fact, apply to the chain defendants'
10 pharmacists in Lake and Trumbull Counties?

11 A. Again --

12 MR. ARBITBLIT: Object to form. Asked
13 and answered.

14 THE WITNESS: I don't have any evidence
15 to suggest that what was being practiced nationally
16 according to pharmacy defendants' chain drugstore
17 policies would not be equally applied to pharmacies in
18 Lake or Trumbull County.

19 BY MR. GISLESON:

20 Q. Do you have any affirmative evidence for any
21 prescriptions in Lake and Trumbull County that time
22 pressures, in fact, caused prescriptions for opioid
23 medications to be issued without a legitimate medical
24 purpose?

25 MR. ARBITBLIT: Object to form. Asked

1 and answered multiple times.

2 MR. GISLESON: She's not answering it.

3 MR. ARBITBLIT: That's your opinion.

4 BY MR. GISLESON:

5 Q. Please answer the question.

6 A. And I feel like I answered the question.

7 Q. Are you able to quantify in any way the number
8 of pharmacists for chain pharmacy defendants who, in
9 your view, experienced time pressure that caused them
10 to fill an opioid medication prescription without a
11 legitimate medical purpose?

12 A. Well, on page 102, the investigation of
13 prescribing practices conducted by the "Chicago
14 Tribune" in 2016 found that 49 percent of chain
15 pharmacies committed fundamental errors in dispensing
16 prescription of two medications --

17 (Reporter clarification.)

18 A. -- that were contraindicated for concurrent
19 use due to risks of severe and potentially fatal
20 adverse effects without warning customers of the
21 danger. The investigators tested 255 pharmacies and
22 found CVS, the nation's largest pharmacy retailer by
23 store count, had the highest fill rate of any chain in
24 the "Tribune" tests.

25 Q. Did any of that data apply to Lake or Trumbull

1 Counties?

2 MR. ARBITBLIT: You're interrupting.

3 It's habitual now. Stop interrupting her.

4 Finish your sentence, please, Doctor.

5 THE WITNESS: Dispensing the medications
6 with no warning 63 percent of the time. Walgreens, one
7 of CVS's main competitors had the lowest failure rate
8 at 30 percent but that's still missing nearly one in
9 three interactions. And also, Walmart pharmacies
10 committed similar errors at a rate of 43 percent.

11 BY MR. GISLESON:

12 Q. What does a pharmacist do when performing a
13 drug utilization review?

14 MR. ARBITBLIT: Objection. Vague.
15 Overbroad.

16 You can answer if you have an answer.

17 THE WITNESS: I feel like I answered
18 that before. Was there an aspect of my prior answer
19 that left something wanting?

20 BY MR. GISLESON:

21 Q. Before this lawsuit, had you ever evaluated
22 prescriptions that had been dispensed for opioid
23 medications by a pharmacy to determine whether the
24 pharmacist dispensed prescriptions without a legitimate
25 medical purpose?

1 A. Not in any systematic way, no.

2 Q. Can you identify any pharmacist working for
3 one of the chain pharmacy defendants that dispensed
4 opioid medications without a prescription?

5 MR. ARBITBLIT: Objection. Form.

6 THE WITNESS: There are multiple DEA
7 enforcement actions cited in my report, and those
8 enforcement actions do identify individual prescribers
9 by name as well as pharmacists who dispensed --

10 BY MR. GISLESON:

11 Q. Can you identify any? Sorry.

12 A. Dispense.

13 Q. Go ahead.

14 A. Yeah, who dispensed opioids not in the context
15 of a legitimate medical condition.

16 Q. Can you identify any pharmacists working in
17 Lake or Trumbull Counties that dispensed opioid
18 medications without a prescription?

19 MR. ARBITBLIT: Objection.

20 THE WITNESS: Again, I think that what
21 was happening nationally was also happening in Lake and
22 Trumbull County. I don't have any data to the
23 contrary, but I can't identify a specific pharmacist by
24 name in Lake or Trumbull County.

25

1 BY MR. GISLESON:

2 Q. Did you speak with any pharmacists in Ohio?

3 A. No.

4 Q. Have you been to either Lake County or
5 Trumbull County?

6 A. I don't -- I may have. I may have briefly.

7 Q. Do you know how many pharmacy stores Rite Aid
8 has in Lake County?

9 A. I do not.

10 Q. Do you know how many pharmacists Rite Aid has
11 in Lake County?

12 A. No.

13 Q. Do you know how many pharmacy stores Rite Aid
14 has in Trumbull County?

15 A. No.

16 Q. Do you know how many pharmacists Rite Aid has
17 in Trumbull County?

18 A. No.

19 Q. Do you know how many stores or pharmacists any
20 of the chain pharmacy defendants have in either in Lake
21 or Trumbull County?

22 A. No.

23 MR. GISLESON: Mr. Ladd, can you please
24 get Tab 3? And Dr. Lembke, if you can go to Tab 3,
25 please.

1 (Exhibit 3 marked for identification.)

2 MR. LADD: Tab 3 has been marked as
3 Lembke Exhibit 3.

4 BY MR. GISLESON:

5 Q. I'd like to show you what has been marked as
6 Lembke Exhibit 3. Have you read Section 1306.04,
7 Purpose of Issue of Prescription?

8 A. Yes, I have.

9 Q. Do you understand this is part of the
10 Controlled Substances Act?

11 A. Yes, I do.

12 Q. This says, "A prescription for a controlled
13 substance to be effective, must be issued for
14 legitimate medical purpose by an individual
15 practitioner acting in the usual course of his
16 professional practice."

17 What do you understand the phrase "legitimate
18 medical purpose" to be in that paragraph?

19 A. An evidence-based purpose.

20 Q. What do you mean by "evidence-based purpose"?

21 A. There is evidence in the literature showing
22 the potential benefits in the use of that medication
23 for that condition outweigh the potential harms.

24 Q. Does the same standard for legitimate medical
25 purpose apply to the prescriber as it does to the

1 pharmacist dispensing the opioid medication?

2 MR. ARBITBLIT: I'm going to object, and
3 interpose it calls for legal conclusion. Belated
4 objection to the prior question on the same grounds.

5 BY MR. GISLESON:

6 Q. Do you have an understanding as to whether the
7 reference to legitimate medical purpose has the same
8 meaning for a prescriber as it does under the statute
9 for a pharmacist?

10 MR. ARBITBLIT: Same objection.

11 THE WITNESS: I don't have an opinion on
12 that.

13 BY MR. GISLESON:

14 Q. Do you know how to determine whether a
15 prescription for an opioid medication has a legitimate
16 medical purpose?

17 MR. ARBITBLIT: Objection. Vague. May
18 or may not call for a legal conclusion depending on
19 whether you're referring to the regulation.

20 BY MR. GISLESON:

21 Q. Do you have the technical ability, based on
22 your training, education, and experience, to evaluate
23 whether a prescription for an opioid medication has a
24 legitimate medical purpose?

25 MR. ARBITBLIT: Same objection.

1 THE WITNESS: Yeah, it would really
2 depend at what point in my career you were talking
3 about. If you were talking about earlier in my career
4 when I, too, had been duped by the opioid
5 pharmaceutical industry, I would not have had the
6 ability to determine that. Having --

7 BY MR. GISLESON:

8 Q. At what point did you have the ability to
9 determine whether an opioid medication prescription had
10 a legitimate medical purpose?

11 MR. ARBITBLIT: Object to form.

12 THE WITNESS: It was a gradual awareness
13 in the early 2000s as I realized that what I had been
14 taught and what I had been told due to the influence of
15 the opioid pharmaceutical industry about the benefits
16 and harms of opioids was not, in fact, based in
17 evidence, and then as I began to review that evidence
18 and also appreciate the extent to which the opioid
19 pharmaceutical industry really amplified myths about
20 opioids, that I could make a decision about the use of
21 opioids in the treatment of pain.

22 BY MR. GISLESON:

23 Q. What is the prospect that -- so you're saying
24 the first time as a practicing physician you were able
25 to determine whether an opioid medication prescription

1 had a legitimate medical purpose was the early 2000s?

2 MR. ARBITBLIT: Object to form.

3 Misstates the testimony.

4 THE WITNESS: Yeah, that overstates my
5 opinion. I'm speaking especially in terms of the use
6 of opioids in the treatment of chronic pain as well as
7 the use of opioids first line for minor pain conditions
8 and the overprescribing in quantity MMEs and the
9 over-dispensing that occurred as a result of paradigm
10 shift.

11 BY MR. GISLESON:

12 Q. What is the process that you follow to
13 determine whether a prescription opioid has a
14 legitimate medical purpose for someone with chronic
15 pain?

16 A. Well, in this case, the process required
17 unravelling years of mis-education, which is something
18 that I am in a unique position to do because I am in an
19 academic medical center. I have more time than the
20 average clinician does to deeply study the literature
21 and to consider these things. Also, by virtue of being
22 an addiction medical specialist, I was really seeing
23 some of the earliest sentinel presentations of patients
24 becoming addicted to opioids through their doctor's
25 prescription, not something that the average clinician

1 would be in a position to see or appreciate. So I came
2 to this much sooner informed by my clinical experience,
3 my reading of the evidence.

4 Q. What is the specific information on which you
5 rely in order to determine whether a prescription from
6 opioid medication has a legitimate medical purpose?

7 MR. ARBITBLIT: Object to form.

8 THE WITNESS: I relied on the medical
9 literature, looking through that literature for studies
10 that might show benefits of opioids longer than three
11 months in the treatment of chronic pain and not finding
12 any such evidence. I also looked for what the risks
13 are associated with opioids at high doses, especially
14 long-term, and found evidence showing that the risks
15 are high, including addiction and overdose death.

16 I then was able to compare the evidence to the
17 misleading messages that I and my peers had been
18 exposed to and see that there was a serious
19 discrepancy.

20 BY MR. GISLESON:

21 Q. What patient-specific information did you
22 consider evaluating whether opioid medications have a
23 legitimate medical purpose for a specific patient?

24 MR. ARBITBLIT: Object to form.

25 THE WITNESS: I'm sorry, could you say

1 that again?

2 BY MR. GISLESON:

3 Q. Sure. What patient-specific information do
4 you consider when evaluating whether a patient should
5 be issued a prescription for an opioid medication?

6 MR. ARBITBLIT: Objection. Overbroad.

7 THE WITNESS: I take many different
8 factors into account but not in a vacuum, so those
9 patient-specific factors like their diagnosis, their
10 history, what other treatments they've tried, how
11 they've responded to those treatments, those all
12 matter, but those cannot be taken in isolation.

13 Especially when it comes to opioid
14 prescribing, I need to consider their family situation.
15 I need to consider more broadly the opioid epidemic and
16 what's happening not just to my individual patients but
17 what is happening to the public health. And when in
18 the midst of an opioid epidemic, I have to consider
19 that the risks of misuse and diversion are very, very
20 high as evidenced by the epidemic itself.

21 So it's many different factors, not just
22 patient-specific factors but also what's happening in
23 the world, what's happening in medicine, the reality of
24 an opioid epidemic. That must come into my
25 consideration as well.

1 BY MR. GISLESON:

2 Q. What documents do you review relating to a
3 specific patient in evaluating whether to prescribe an
4 opioid medication?

5 A. I rely on the prescription drug monitoring
6 database; very important. I rely on that patient's
7 prior medical records when I have access to those. I
8 try to get collateral information from other
9 prescribers, from pharmacists. I rely on what the
10 patient him or herself says about their disease
11 process.

12 Q. Anything else?

13 A. I also rely on epidemiologic data, what very
14 large data trends show in terms of treatments and
15 outcomes, risks, benefits, and alternatives.

16 Q. Any other patient-specific documentation or
17 information on which you rely?

18 A. Sometimes I rely on laboratory studies when
19 those are indicated.

20 Q. X-rays?

21 A. Yes, sometimes.

22 Q. Anything else?

23 A. Well, there are other laboratory studies, but.

24 Q. Is there a generally-applicable standard in
25 the medical community for what a legitimate medical

1 purpose means for a prescription for opioid
2 medications?

3 MR. ARBITBLIT: Object to form.

4 THE WITNESS: The language that is used
5 today in medicine is evidence-based medicine. That is
6 the mantra that overrides almost everything that we do.
7 If there is evidence for a particular treatment or
8 evidence to suggest that the harms of that treatment
9 outweigh any potential benefits, then that is our
10 guiding light.

11 BY MR. GISLESON:

12 Q. Is the prescriber supposed to weigh the risks
13 and the benefits of opioid treatment?

14 MR. ARBITBLIT: Object to form.

15 THE WITNESS: The prescriber can only
16 weigh risks and benefits to the extent that they know
17 what those risks and benefits are.

18 BY MR. GISLESON:

19 Q. How was the pharmacist, in your view, supposed
20 to determine whether a prescription for opioid
21 medications has a legitimate medical purpose?

22 A. The pharmacist has many different vehicles by
23 which to do that. The pharmacists could have and
24 should have checked the prescription drug monitoring
25 database to look for red flags for misuse and diversion

1 for a given prescription. The pharmacies should have
2 made that mandatory for their pharmacists. The
3 pharmacies should have made available to pharmacists
4 data, not just on patient red flags but also on
5 prescriber red flags, and which prescribers might be
6 engaging in the equivalent of pill-mill prescribing.

7 The pharmacists need to, and the pharmacies,
8 need to keep up with the medical literature on the
9 potential risks and benefits including dangerous drug
10 combinations. The pharmacies and pharmacists also need
11 to have policies and incentives in place that allow
12 pharmacists to actually exercise their due diligence
13 and good judgment. And then there are also, as I've
14 stated before, other data that a pharmacist and a
15 pharmacy can rely on to suggest possible misuse and
16 diversion that even the prescribing doctor does not
17 have access to. Which is why this corresponding
18 responsibility is so important for everybody in the
19 supply chain.

20 Q. And then the pharmacist, in your view, is to
21 take all that information in the context of the
22 prescription in the individual patient and make the
23 decision whether or not to dispense the opioid
24 medication?

25 MR. ARBITBLIT: Object to form.

1 THE WITNESS: If the pharmacist has
2 access to true information and is working in an
3 environment where they're encouraged to do their due
4 diligence and to not dispense when red flags, after
5 being appropriately investigated, have demonstrated
6 that the potential risks outweigh the harms, only then
7 can pharmacists exercise their clinical judgment and
8 make a decision about dispensing.

9 BY MR. GISLESON:

10 Q. Whose standard is that?

11 MR. ARBITBLIT: Object to form.

12 THE WITNESS: That's the Controlled
13 Substances Act.

14 BY MR. GISLESON:

15 Q. What do you mean by "true information"?

16 A. One of the problems with the Ohio prescription
17 drug monitoring database laws is that pharmacists were
18 required to check -- only after they had detected red
19 flags for misuse and diversion, when, in fact, checking
20 the prescription drug monitoring database is the very
21 way that a pharmacist could determine if there are red
22 flags for misuse and diversion. Without checking that
23 database, it's not possible to know if those red flags
24 exist. A pharmacist --

25 Q. I'm sorry, continue.

1 A. So a pharmacist trying to exercise his or her
2 good clinical judgment on whether or not to dispense,
3 cannot do so unless they have availed themselves of all
4 of the data at their disposal.

5 Now, a pharmacist is not going to have access
6 to every piece of data in the known universe, but what
7 they have access to, they need to check in order to
8 make an informed clinical decision.

9 MR. ARBITBLIT: Counsel, we've been
10 going for 75 minutes. That seems to be a reasonable
11 time for a ten-minute break, if you're at a break
12 point.

13 MR. GISLESON: Yeah, that's fine.

14 THE VIDEOGRAPHER: We are going off the
15 record at 1:29.

16 (Recess taken 1:29 p.m. to 1:42 p.m.)

17 THE VIDEOGRAPHER: We are back on the
18 record. The time is 1:42. Please proceed.

19 BY MR. GISLESON:

20 Q. How many years of school does a pharmacist
21 have to complete in order to become a licensed
22 pharmacist?

23 A. I don't know.

24 Q. What are the requirements for a pharmacist --
25 strike that.

1 What are the requirements for a pharmacist to
2 achieve a Doctorate of Pharmacy?

3 A. I assume it's additional training.

4 Q. Specifically, what must a pharmacist do to
5 achieve a doctorate in pharmacy?

6 A. I don't know.

7 Q. Do pharmacists take any internships while
8 they're in pharmacy school?

9 A. Probably.

10 Q. What?

11 A. I don't know the specific names.

12 Q. Do pharmacists receive any training in
13 pharmacy school relevant to satisfying their
14 corresponding responsibility?

15 A. Yes, I would assume so.

16 Q. Do you know for a fact whether pharmacists
17 receive any training in pharmacy school on what they
18 must do to satisfy their corresponding responsibility
19 when it comes to dispensing opioid medications?

20 A. No.

21 Q. What information is on the licensing exam for
22 pharmacists?

23 MR. ARBITBLIT: Object to form.

24 THE WITNESS: I have never looked at a
25 licensing exam so I can't tell you at that specific

1 level of detail.

2 BY MR. GISLESON:

3 Q. What continuing medical education requirements
4 do pharmacists have in Ohio?

5 A. I don't know what their exact requirement
6 numbers, but like all healthcare providers they have
7 additional continuing education requirements.

8 Q. Did you do any investigation into what those
9 continuing medical education requirements are in Ohio?

10 A. No.

11 Q. What's the difference between a pharmacist and
12 a pharmacy technician?

13 A. Level of training.

14 Q. What is a pharmacy technician permitted to do?

15 A. I don't know exactly the difference in
16 responsibilities.

17 Q. Can you identify any pharmacists for any of
18 the chain pharmacy defendants who knowingly dispensed
19 an opioid medication without a legitimate medical
20 purpose?

21 A. Not by name, but my opinion is based on the
22 aggregate.

23 Q. Go to page 76 in your report, please. In
24 paragraph 6 you write, "Pharmacies leveraged their
25 unique and pivotal position in the opioid supply chain

1 to contribute to the unprecedented and unchecked flow
2 of opioid pain pills into the community."

3 What do you mean by "unchecked flow of opioid
4 pain pills into the community"?

5 A. By that I mean where pharmacy defendants had
6 an opportunity to assess for misuse and diversion and
7 opioids not dispensed for a legitimate medical
8 condition for a legitimate physician-patient
9 relationship, they did not take those opportunities to
10 the extent that they should have as early as they
11 should have, with as much due diligence as they should
12 have. And instead, they did the opposite and
13 incentivized the outflow of prescriptions, or as one of
14 the pharmacy defendants, a manager stated their stores
15 became a literal, quote, unquote, "funnel for opioid
16 prescriptions getting out into the community."

17 Q. Is it your testimony that none of the
18 pharmacists for the chain pharmacy defendants assessed
19 opioid prescriptions for misuse and diversion?

20 MR. ARBITBLIT: Objection. Misstates.

21 THE WITNESS: That's not what I said.

22 BY MR. GISLESON:

23 Q. Do you agree that the pharmacists for the
24 chain pharmacy defendants assessed whether misuse and
25 diversion would occur with respect to particular opioid

1 medication prescriptions?

2 MR. ARBITBLIT: Object to form.

3 THE WITNESS: The evidence in aggregate
4 shows that pharmacists were disempowered and unable to
5 exercise their clinical judgment because they neither
6 had the time nor access to the necessary information to
7 determine misuse and diversion when dispensing opioids.
8 And furthermore, they were highly incentivized through
9 bonuses, et cetera, to dispense more opioids. So where
10 pharmacy defendants could have and should have put on
11 the brakes, instead they pressed down on the
12 accelerator.

13 BY MR. GISLESON:

14 Q. What work did you perform to determine whether
15 pharmacists for the chain pharmacy defendants assessed
16 whether misuse and diversion would occur with respect
17 to particular opioid medication prescriptions in Lake
18 and Trumbull County?

19 A. Well, I reviewed DEA evidence. I reviewed
20 internal documents from defendants themselves. I
21 reviewed the CSA. I reviewed the messages that went to
22 pharmacists and directly to patient consumers and
23 through that steppingstone to prescribers themselves.
24 I reviewed the collaborations that pharmacy defendants
25 had with distributors and manufacturers, which the

1 documents themselves describe as, quote, unquote,
2 "mutually beneficial arrangements."

3 All of those evidence in aggregate speak to a
4 national and systemic policy among defendants'
5 pharmacies for not doing their part to combat the
6 opioid epidemic and contributing to the opioid epidemic
7 including Lake and Trumbull Counties because I have not
8 seen any evidence to suggest that by some miracle Lake
9 and Trumbull Counties are different from the rest of
10 the United States.

11 Q. What tests did you perform to determine
12 whether any pharmacists for any of the chain pharmacy
13 defendants were financially incentivized to fill opioid
14 medication prescriptions without a legitimate medical
15 purpose?

16 A. The financial incentive programs across
17 defendants' pharmacies were national types of policies.

18 Q. Anything specific to the pharmacists in Lake
19 and Trumbull Counties?

20 A. I don't have any reason to believe Lake and
21 Trumbull Counties are an exception.

22 Q. Did you perform any tests of any kind or
23 analyses to determine whether the pharmacists in Lake
24 and Trumbull County for the chain pharmacy defendants,
25 in fact, filled opioid prescriptions without a

1 legitimate medical purpose because of incentive
2 programs that were made available?

3 MR. ARBITBLIT: Objection. Vague.

4 THE WITNESS: My report is my analysis.
5 The aggregate of all of the information in my report
6 taken together, lead me to the opinion that pharmacists
7 in Lake and Trumbull County were operating in the same
8 conditions as pharmacists in defendants' pharmacies all
9 over the United States.

10 BY MR. GISLESON:

11 Q. So in terms of your assessment of the chain
12 defendants' pharmacists and pharmacies in Lake and
13 Trumbull County, you are relying on evidence from
14 outside of Lake and Trumbull County to draw your
15 conclusions?

16 MR. ARBITBLIT: Objection. Misstates
17 the record.

18 THE WITNESS: I'm relying on all kinds
19 of different evidence, and I would just add that
20 evidence demonstrating defendant pharmacies dispensing
21 opioids in a way that put the public at-risk also puts
22 Lake and Trumbull County at-risk because we know that
23 these pills migrate from Florida all the way up the
24 Blue Highway to Ohio.

25 In my report, there is a DEA enforcement

1 showing that one of the prescribers who the DEA found
2 negligent had patients who were filling prescriptions
3 in Ohio, even though he himself resided in Florida, so
4 these pills travel.

5 BY MR. GISLESON:

6 Q. When you say that there was an unchecked flow
7 of opioid pain pills into Lake and Trumbull Counties,
8 is it your testimony that the pharmacists for the chain
9 defendants did not evaluate the individual
10 prescriptions to determine whether they had a
11 legitimate medical purpose?

12 MR. ARBITBLIT: Object to form.
13 Misstates the record.

14 THE WITNESS: Again, my opinion and my
15 testimony and what's in my report all speaks to the
16 pharmacy defendants not having done enough early enough
17 to really prevent the opioid epidemic. Although it was
18 within their will and their power to do so, they chose
19 to nibble at the edges, getting away with bear minimum
20 instead of what they really could have done to prevent
21 misuse and diversion.

22 BY MR. GISLESON:

23 Q. You said that doctors were duped. Do you
24 believe pharmacists could have been duped as well about
25 the safety and efficacy of opioids?

1 A. I think the more important question is whether
2 or not pharmacies themselves were duped, and it's very
3 clear that pharmacies themselves were not duped, that
4 the pharmacy leadership was in active collaboration
5 with on opioid manufacturers and distributors to
6 increase the supply of opioids, because it was mutually
7 beneficial for their business bottom line.

8 And in instances that I cite in my report,
9 pharmacies were, in fact, leading the way. Walgreens
10 University is a nice example of that, but there are
11 others. So pharmacies were not duped.

12 Q. Move to strike as nonresponsive.

13 You said that doctors were duped. Do you
14 believe that pharmacists in Lake and Trumbull County
15 working for the chain pharmacy defendants could have
16 been duped as well about the safety and efficacy of
17 opioid medications?

18 A. It's certainly possible that individual
19 pharmacists were duped, but even those who knew the
20 evidence were clearly not allowed to exercise their
21 clinical judgment based on science because of the
22 pressures on them to dispense large amounts of opioids.
23 And I cited the letter from a Mr. Yaeger talking about
24 how he actually felt physically intimidated by his
25 pharmacy managers to dispense prescription opioids,

1 even when he had investigated the presence of a red
2 flag and decided not to dispense. And there are many,
3 many other examples showing that pharmacies across the
4 nation, including defendant pharmacies, felt similarly.

5 Q. Move to strike as nonresponsive except for the
6 point about it being certainly possible that individual
7 pharmacists were duped.

8 If you can go, please, to page 76 and to 77
9 you write, "Their coordinated efforts to create demand
10 including advertising specific opioid products at the
11 pharmacy counter, building opioid superstores to
12 enhance unrestricted flow of opioid pain pills,
13 spreading misinformation about the safety and efficacy
14 of opioid pain pills, arguing with pro-opioid industry
15 and advocacy and lobbying organizations and then
16 ignoring red flags for misuse and diversion including
17 concerns expressed by their own pharmacists, failing to
18 provide pharmacists with sufficient time, resources, or
19 incentives to investigate red flags and failing to use
20 or analyze their own dispensing data to assist
21 pharmacies in identifying red flags."

22 Can you identify any pharmacy anywhere in the
23 country that aggregates their dispensing data and runs
24 analyses to look for prescriber red flags?

25 A. It's my belief that pharmacies had and have

1 the ability to create that kind of database, and as
2 part of their corresponding responsibility, according
3 to the Controlled Substance Act it is on pharmacies to
4 create a surveillance system that will detect and
5 prevent misuse and diversion. So if pharmacy
6 defendants are going to claim they don't have that kind
7 of database, they certainly could make one.

8 Q. Move to strike as nonresponsive.

9 Can you identify any pharmacy anywhere in the
10 country that aggregates dispensing data and runs an
11 analysis to look for prescriber red flags?

12 A. One moment, please. I'm ready, sorry. I
13 would refer to page 124 of my report where I state that
14 "no CVS policy or procedure that I have reviewed makes
15 reference to pharmacist's ability to utilize CVS's own
16 dispensing data to assist in identifying prescriber
17 related red flags such as overprescribing, prescribing
18 of higher dosages, prescribing patterns, or percentage
19 of controlled and non-controlled prescribing."

20 I infer that CVS did not make its database
21 available to its pharmacies for such information, and
22 furthermore, CVS made it more difficult to access that
23 information in the 2004 policy and procedure on
24 professional practices, quote, "blanket decisions based
25 on a practitioner's prescribing habits or customer's

1 appearance are unprofessional and may be illegal," and
2 yet despite that statement, in their 2004 policy --

3 Q. Doctor, again, you're not answering the
4 question that I asked. My specific question --

5 A. I'm almost there. I'm getting there.

6 As you see, according to their policy in 2014,
7 they actually were able to implement a system whereby
8 pharmacists could issue blanket prescription vetoes for
9 certain providers. So that's page 128 of my report
10 where I say the policy allowed CVS to block, quote,
11 "prescribers who CVS, as part of corresponding
12 responsibility, has decided not to dispense their
13 controlled substance prescriptions.

14 "So contrary to the ROPP described above
15 effective in 2004, the 2014 policy appears to confirm
16 that CVS had the ability to issue blanket refusals to
17 fill based on the prescriber's behavior regardless of
18 patient red flags."

19 So clearly, they had the data, they had access
20 to the data, they, in certain instances, created the
21 database.

22 Q. Move to strike as nonresponsive.

23 Now, is it your position that the pharmacies
24 created demand for patients to use prescription
25 opioids?

1 A. Yes.

2 Q. How?

3 A. So just again referring to my Opinion No. 6 on
4 page 76, pharmacies were in a unique position,
5 straddling distributors, manufacturers, and the
6 patients themselves. Pharmacies are -- and pharmacists
7 are among the most trusted healthcare professionals
8 that we have today based on consumer survey reports.
9 So these individuals are very influential when it comes
10 to patient's beliefs about prescriptions. And it's
11 very clear that the pharmacies collaborated with
12 manufacturers and distributors to train their
13 pharmacists to propagate non-evidence-based ideas about
14 the use of opioids in the treatment of pain.

15 And furthermore, had programs in place where
16 pharmacists were incentivized to promote certain
17 products at the pharmacy counter, which these types of
18 programs were typically named adherence -- adherence
19 programs.

20 There is also evidence that the pharmacy
21 defendants were invested in collaborating with Purdue
22 to create so-called opioid superstores. These were
23 pharmacies that were basically the equivalent of
24 pill-mill clinics for pharmacies where opioids would
25 always be readily available and where prescriptions

1 would not be questioned, contributing to the
2 unrestricted flow of opioid pain pills.

3 There is plenty of evidence that the
4 pharmacies create a demand by spreading misinformation
5 about the safety and efficacy of pain pills. In many
6 different ways, partnering, not just with opioid
7 manufacturers and distributors to do that, but also
8 partnering with professional medical societies and
9 creating patient-facing brochures in order to propagate
10 myths about opioids, which contributed to paradigm
11 shift, which contributed to the increase in supply of
12 opioids.

13 Q. Specifically as to Lake and Trumbull Counties,
14 do you have any evidence that in Lake or Trumbull
15 County any of the chain pharmacy defendants in fact
16 caused a patient to obtain an opioid prescription that
17 patient otherwise would not have obtained?

18 MR. ARBITBLIT: Objection. Form.

19 THE WITNESS: So the paradigm shift was
20 a national paradigm shift, and Lake and Trumbull
21 Counties are not exclusive to that, and my report does
22 contain specific instances of these misleading messages
23 which created a paradigm shift being disseminated in
24 Ohio and very likely also in Lake and Trumbull
25 Counties.

1 BY MR. GISLESON:

2 Q. Do you have any evidence that in Lake or
3 Trumbull Counties any of the chain pharmacy defendants
4 in fact caused a patient to obtain an opioid
5 prescription that the patient otherwise would not have
6 obtained?

7 MR. ARBITBLIT: Object to form.

8 THE WITNESS: Again, I have no evidence
9 to the contrary and lots of evidence showing that this
10 is a national -- this was a national campaign, that
11 these are systemic issues, that these are top-down
12 corporate policies that affect the entire chain.

13 BY MR. GISLESON:

14 Q. Do you have any evidence that in Lake or
15 Trumbull County any of the chain pharmacy defendants in
16 fact caused a patient to obtain an opioid prescription
17 that patient otherwise would not have obtained?

18 MR. ARBITBLIT: Objection. Form. Asked
19 and answered.

20 MR. GISLESON: She hasn't answered it.

21 MR. ARBITBLIT: That's your opinion.

22 MR. GISLESON: That's a fact.

23 BY MR. GISLESON:

24 Q. Answer the question, please, Doctor.

25 MR. ARBITBLIT: It's your opinion that

1 that's a fact.

2 BY MR. GISLESON:

3 Q. Answer the question, please, Doctor.

4 A. Yeah, I've answered that question to the
5 best --

6 Q. No, you haven't.

7 MR. ARBITBLIT: Argumentative.

8 BY MR. GISLESON:

9 Q. Can you identify any specific prescriber in
10 Lake or Trumbull County that issued a prescription for
11 an opioid medication because of a specific action taken
12 by a pharmacist at one of the chain pharmacies in Lake
13 or Trumbull County?

14 MR. ARBITBLIT: Object to form.
15 Badgering.

16 THE WITNESS: I don't have a different
17 answer than the answer I have given before.

18 BY MR. GISLESON:

19 Q. So you cannot identify any specific piece of
20 evidence from Lake or Trumbull County to support your
21 opinion?

22 MR. ARBITBLIT: Object to form.
23 Badgering. Argumentative. Asked and answered.

24 THE WITNESS: Yeah, that misstates that
25 I've said before.

1 BY MR. GISLESON

2 Q. Do you agree that it's wrong for an expert to
3 be totally biased in a lawsuit?

4 A. That's just rude.

5 Q. Do you agree that it's wrong for an expert to
6 be totally biased in a lawsuit?

7 MR. ARBITBLIT: Object to form.

8 THE WITNESS: If you're implying that
9 I'm totally biased, I'm not.

10 BY MR. GISLESON:

11 Q. Do you agree that it's wrong for an expert to
12 be totally biased in litigation?

13 A. I don't have an answer to that question. You
14 know, you're obviously trying to imply something about
15 me. I don't think that that question really warrants
16 an answer.

17 Q. You said that "opioid manufacturers and
18 distributors worked together with pharmacies to market
19 specific opioids at the pharmacy counter."

20 What marketing occurred at the pharmacy
21 counter in Lake and Trumbull Counties?

22 A. Pharmacists in the defendants' chains were the
23 recipients of promotional messages that were very
24 pro-opioid. I do talk in my report about the direct
25 ADHERE program in which Butrans and Kadian were

1 promoted at the pharmacy counter. Specifically Walmart
2 and Giant Eagle partnered with McKesson around that.

3 Q. Did you identify any marketing that occurred
4 at the pharmacy counter in Lake or Trumbull County by
5 any of the pharmacy defendants?

6 A. Part of the marketing that occurred was the
7 promotion of coupons for discounted opioids and the
8 exchange of those coupons with embedded promotional
9 material occurred at the pharmacy counter.

10 Q. Whose coupons?

11 A. Janssen, Nucynta, and Duragesic.

12 Q. So these were manufacture coupons, not a chain
13 pharmacy defendant's coupon?

14 A. That's correct. Although the distributors and
15 the pharmacies collaborated around those coupons.
16 There was also advertising for specific opioid products
17 in the pharmacies.

18 Q. What do you mean?

19 A. On page 71 of my report, a 2012 document
20 titled "McKesson Manufacturing Marketing," talks about
21 how, quote, "McKesson partners with pharmaceutical
22 manufacturers such as Cephalon to define and actually
23 customize strategies targeting key awareness, sales,
24 and distribution goals at all stages of the product
25 cycle."

1 Q. So are you faulting, then, the chain pharmacy
2 defendants for accepting from their customers a
3 manufacturer's coupon that made opioid medication more
4 affordable?

5 MR. ARBITBLIT: Object to form.

6 THE WITNESS: No. That is not what I
7 said.

8 BY MR. GISLESON:

9 Q. Can you identify any chain pharmacy pharmacist
10 in Lake or Trumbull County who dispensed an opioid
11 medication without a legitimate medical purpose because
12 the customer presented a coupon?

13 A. I do believe that somewhere in my report is
14 evidence for these coupons being used in Ohio, probably
15 including Lake and Trumbull County. On page 75 of my
16 report, in 2013, McKesson promoted its pharmacy
17 intervention program by letting Purdue know about their
18 pharmacy brand kit.

19 (Reporter clarification.)

20 A. "The brand-specific pharmacy kit is mailed to
21 each participating pharmacy prior to launch. This kit
22 includes a cover letter and coaching guide. Purdue
23 will have the opportunity to participate in the
24 development and review of all pharmacy materials
25 specific to their program. The brand kit can also

1 include any additional resources that pharmacists
2 should read as well as patient brochures to hand out
3 during the coaching session. Purdue would develop and
4 provide," unquote.

5 It goes on to page 76 and also prior to page
6 74, about how page 71 --

7 Q. Move to strike as nonresponsive.

8 A. Also on page 78, CVS CareMark courted opioid
9 manufacturers by promising, quote, "identifying
10 patients who may benefit from your product," unquote,
11 and increasing, quote, "awareness of new treatments of
12 therapies," unquote, including a pharmacy literature
13 display to, quote, "educate patients via literature
14 located adjacent to prescription counter."

15 Q. Move to strike --

16 A. The same --

17 Q. -- nonresponsive.

18 A. -- for 2011 document states, quote,
19 "Communicate your products --

20 Q. Thank you. You've responded, Doctor.

21 A. Thank you.

22 Q. You're now just wasting time.

23 Are you able to design a study that could
24 determine the extent to which individuals in Lake and
25 Trumbull County developed an opioid use disorder as a

1 result of taking an opioid medication under a doctor's
2 care?

3 MR. ARBITBLIT: Object to form.

4 THE WITNESS: So again, I cite
5 literature in my report that has conducted such studies
6 looking at the risk of becoming addicted to opioids in
7 patients with chronic pain who have become addicted
8 specifically to the opioids their doctors are
9 prescribing, and I detail that study in my report.

10 BY MR. GISLESON:

11 Q. Are there any studies specific to Lake and
12 Trumbull Counties as to individuals who developed
13 opioid use disorder as a result of taking prescription
14 opioids pursuant to a doctor's prescription?

15 MR. ARBITBLIT: Object to form.

16 THE WITNESS: Again, there is no reason
17 to believe that Lake and Trumbull County will be
18 outliers in this case.

19 BY MR. GISLESON:

20 Q. Does the report in this case contain all of
21 your opinions?

22 A. Based on the materials reviewed to date, yes.

23 Q. And does it identify all of the materials on
24 which you relied in forming your opinions?

25 A. Yes.

1 Q. Is all of the wording in the report yours?

2 A. Yes.

3 Q. Did you copy any of the material in your
4 report from another source?

5 A. Not as far as I know, no. I mean, this is --
6 I have issued prior reports, and so there is --

7 Q. Which report which report did you update with
8 this one?

9 A. I'm sorry. I don't understand your question.

10 Q. Did you update a prior report in creating this
11 report?

12 A. My process of research has been ongoing over
13 many years, and as I review more material, I assess it
14 and I revise the report as I go along based on the
15 information, the new information that I gather.
16 Nothing that I have reviewed has changed my fundamental
17 opinion.

18 Q. Did you start with a prior report that you
19 supplemented to include allegations against the
20 pharmacy defendants?

21 A. Yes.

22 Q. Which report?

23 A. The MDL report.

24 Q. For which track?

25 A. The original MDL report and then a subsequent

1 West Virginia report.

2 MR. GISLESON: Don, I have more
3 questions but to make sure that the other folks have a
4 chance to ask their pharmacy-specific questions, I'm
5 going to pass the witness for now. Is that all right?

6 MR. ARBITBLIT: Well, it's okay with me.
7 I'm not saying that there is going to be time left when
8 they're done.

9 MR. GISLESON: I realize that. So
10 Kasper?

11 MR. STOFFELMAYR: I can ask a few
12 questions. Doctor, are you okay to keep going or do
13 you need a break?

14 THE WITNESS: I'm okay.

15 MR. STOFFELMAYR: Okay, thank you.

16 EXAMINATION

17 BY MR. STOFFELMAYR:

18 Q. Doctor, my name is Kasper Stoffelmayr, and I
19 represent the Walgreens chain. I want to start with a
20 couple of questions, not about pharmacies but about
21 heroin addiction. That's also one of your areas of
22 expertise, correct?

23 A. Yes.

24 Q. As I understand it, and please correct me if
25 I'm misusing the terminology, there is a group, maybe a

1 small group of heroin addicts who are sometimes called
2 high-functioning addicts who can remain -- you know,
3 have heroin use careers that can last many years or
4 decades, correct?

5 A. Yes.

6 Q. And am I right that that is relatively unusual
7 for somebody to be able to continue using heroin for
8 decades without having something catastrophic happen?

9 A. I really couldn't answer that. There is not a
10 lot of data or much written on that group. It's known
11 to exist, but there is not a lot of information.

12 Q. Let me ask it this way: Among the people you
13 treat or have encountered in your professional career,
14 am I right that most heroin users will use heroin for a
15 period of years and then will either successfully be
16 able to stop using heroin to recover or unfortunately
17 pass away, that it's unusual for someone to have used
18 heroin for a decade by the time you see them?

19 A. I wouldn't say that's true. In my clinical
20 experience, I have had patients who have used heroin
21 for a very long time. The biggest problem with that
22 population is not about the molecule itself because
23 really it's fundamentally the same as a prescription
24 opioid. The difference is how they can obtain it. And
25 because heroin is illegal, they have to engage in

1 illegal activity to get their drug, which introduces
2 other factors and other variables. So they may seek
3 treatment, not because they've had some kind of
4 catastrophic event, but because they've run into law
5 enforcement problems.

6 Q. Let me ask the question this way. Let me ask
7 more broadly about opioid use more generally. I don't
8 need to ask specifically about heroin use. But among
9 people who misuse opioids, whether it's heroin or
10 non-medical use of prescription drugs, is there any
11 data available on what's the average length of
12 someone's opioid misuse career -- if there is a better
13 term, please tell me -- the average length of their
14 period of opioid misuse before they either successfully
15 seek treatment or do unfortunately pass away or stop
16 using for other reasons?

17 A. Well, there are some data suggesting that on
18 average it takes about three years to develop an opioid
19 use disorder from the time that the prescription opioid
20 was initiated. That's slightly different from the
21 question you're asking, which is once the opioid use
22 disorder has developed, how long it takes them to get
23 into treatment or have some kind of catastrophic event.
24 And I'm not right now recalling any specific data on
25 that. I think that's probably really hard data to come

1 by because people are not going to be forthcoming about
2 their opioid addiction in most instances.

3 Q. Is there any way you're aware of to
4 investigate this question: If we look at the
5 population of heroin users today, either nationwide or
6 pick a geography, but if we look at the population of
7 heroin users today to be able to determine how many of
8 them were misusing heroin or a different opioid, say,
9 five years ago or 10 years ago or 15 years ago?

10 A. I'm not -- it's not coming to mind right now,
11 you know, specific data on that.

12 Q. All right. Let me switch gears. You
13 mentioned Walgreens University two or three times
14 today. You recall that, correct?

15 A. Yes.

16 Q. Now, Walgreens University is not actually
17 mentioned anywhere in your report, is it?

18 A. The document that is called Walgreens
19 University is cited in my report.

20 Q. Correct. There is a document cited in your
21 report that if you pull up the document it says
22 Walgreens University, but there is no discussion of
23 this university in the report, correct?

24 A. No, I do discuss this footnote 417. I discuss
25 that Walgreens collaborated with Purdue, is manifest by

1 the remarkable sales of OxyContin at Walgreens
2 pharmacies. And in this Walgreens University document,
3 they talk about how Walgreens distributes 374 million
4 of Purdue's prescription product, 16.8 percent, and how
5 Walgreens is the largest of the greater than 200 retail
6 chains --

7 (Reporter clarification.)

8 A. -- that dispense Purdue prescription products.
9 And then, likewise, romanette 17 talks about how
10 OxyContin sales at Walgreens stores continue to be very
11 high, even through 2017. And then I include this
12 table, all of which is from that document.

13 Q. That is a document -- strike that.

14 The document you're describing is a Purdue
15 presentation, correct?

16 A. I would have to refresh my memory on that. My
17 recollection is that Purdue executives went to a
18 Walgreens site and actually on a Walgreens campus led
19 by Walgreens top representatives had this exchange.
20 So --

21 Q. The table, for example, at the bottom of
22 page 84 of your report, that is a table that you cut
23 and pasted out of a Purdue presentation, correct?

24 A. That table is out of the same Walgreens
25 University document.

1 Q. That document is a Purdue presentation,
2 correct?

3 A. I'm not exactly remembering.

4 Q. If we looked at it, we would see a Purdue logo
5 on it, wouldn't we?

6 MR. ARBITBLIT: Counsel, if you have the
7 document, you might save some time.

8 MR. STOFFELMAYR: I do not have the
9 document, sir. She cited that she cut and pasted it
10 into her report. I'm asking her -- she's mentioned
11 Walgreens University several times. I need to know --

12 MR. ARBITBLIT: She said she didn't
13 remember that specific -- she said she didn't remember
14 that specific document.

15 Dr. Lembke, if you have a recollection, you
16 can offer it.

17 THE WITNESS: I don't remember if the
18 Purdue logo was at the top. I do remember that this
19 was an event that occurred on a Walgreens campus with
20 Purdue executives going to the campus to engage in this
21 collaborative exchange which was called Walgreens
22 University.

23 BY MR. STOFFELMAYR:

24 Q. Dr. Lembke, tell me everything you know about
25 Walgreens University.

1 A. Well, can we pull up the document?

2 Q. We cannot. Tell me everything you know about
3 Walgreens University.

4 MR. ARBITBLIT: Object to form. Without
5 the document, it's -- that's all.

6 MR. STOFFELMAYR: We don't need your
7 testimony, Don.

8 MR. ARBITBLIT: Yeah, object to form.

9 THE WITNESS: I have told you in my
10 report what I had to say about the document. It's in
11 my report. And beyond that, I would really like to
12 look at the document itself to refresh my recollection.
13 BY MR. STOFFELMAYR:

14 Q. Do you have any information about Walgreens
15 University other than what is in the one document cited
16 in your report?

17 A. No.

18 Q. In preparing your report, did you make any
19 effort to learn anything at all about Walgreens
20 University?

21 MR. ARBITBLIT: Object to form.

22 THE WITNESS: Yes. I wanted to know
23 whether or not it was a Purdue-led initiative or a
24 Walgreens-led initiative, and based on what I reviewed,
25 as I'm recalling as I sit here today, that this was a

1 Walgreen-led initiative on the Walgreens campus
2 entitled Walgreens University and that Purdue was, in
3 effect, their student.

4 BY MR. STOFFELMAYR:

5 Q. Did you Google Walgreens University?

6 A. No.

7 Q. Other than review one document about Walgreens
8 University, what steps did you take to learn about
9 Walgreens University?

10 A. As I'm recalling, I tried my best to do due
11 diligence about who was actually initiating this
12 meeting, and as I'm recalling today, it was a
13 Walgreens-led collaboration with Purdue. Walgreens was
14 not the passive recipient of Purdue material. This was
15 something that Walgreens was invested in.

16 Q. I think you misunderstood my question, Doctor.
17 Other than reviewing one document, what steps did you
18 take to educate yourself about Walgreens University?

19 A. I'm not recalling that I took any additional
20 steps.

21 Q. How did you locate the one document about
22 Walgreens University that we've been discussing?

23 A. That was provided to me by Counsel as part of
24 discovery.

25 Q. Do you remember earlier in response to some

1 questions from Mr. Gisleson you described Walgreens
2 University as providing continuing medical education to
3 prescribing doctors. Do you recall talking about that?

4 A. Well --

5 MR. ARBITBLIT: Object to form,
6 misstates.

7 BY MR. STOFFELMAYR:

8 Q. That does not misstate at all. I'll read it
9 out loud if you like.

10 Go ahead, Doctor.

11 A. Sure, could you read it out loud? That would
12 be great.

13 Q. The question Mr. Gisleson asked you was, "It
14 was the manufacturers who were providing the continuing
15 medical education to the prescribing doctors; is that
16 correct?"

17 Dr. Lembke, you said, "No, on page 84, I
18 specifically reference a Walgreens University document
19 from 2017 where Purdue was, in fact, Walgreens' student
20 at this continuing medical education event."

21 Do you recall now that you earlier testified
22 that Walgreens University was involved in providing
23 continuing medical education to prescribing doctors?

24 A. Yes, it's fair to say that my answer was not
25 entirely accurate in the sense that Walgreens

1 University was prescribing -- was communicating
2 information to Purdue pharma reps, and not prescribers.

3 Q. And in fact, you're not aware of any instance
4 in which Walgreens or any other pharmacy chain provided
5 continuing medical education to prescribing doctors,
6 correct?

7 A. That is correct.

8 (Reporter clarification.)

9 Q. I'm sorry. I said let's look on page 84,
10 there is a chart you mentioned, Doctor, showing
11 OxyContin sales at Walgreens stores, correct?

12 A. Yes.

13 Q. And do you see that between 2010 and 2011, the
14 sales went up by 33.9 percent according to this chart?

15 A. Yes.

16 Q. Why is that? Do you have any understanding at
17 all?

18 A. Well, that's consistent with national trends
19 in opioid prescribing that increased through 2012, 2013
20 before, generally, they began to decrease again.

21 Q. Why was the increase from 2010 to 2011 so
22 large compared to the increase between 2011 and 2012?

23 A. I'm not sure.

24 Q. Did anything other than increased prescribing
25 change between 2010 and 2011 that might help to explain

1 that 33.9 percent increase?

2 A. Not that I can think of right now.

3 Q. Okay, then you see in 2013, it goes down by
4 17.6 percent. Do you see that?

5 A. Yes.

6 Q. Do you have any understanding of why OxyContin
7 sales at Walgreens went down so much between 2012 and
8 2013?

9 A. That general time frame may be because it was
10 around that time that the CDC came out saying that
11 we're in the midst of a prescription drug epidemic
12 implicating prescription opioids as a major causative
13 factor. With those types of pronouncements, typically
14 there is some delay in terms of the response. That is
15 also roughly the time that opioid prescribing
16 nationally began to decrease, so that may explain the
17 decrease at that point.

18 Q. The chart you have on page 84, that shows
19 sales measured in dollars, not dosage units or MME,
20 correct?

21 A. That is true, yes.

22 Q. During this time period from 2010 to 2017, did
23 the price of OxyContin -- excuse me. Let me ask that
24 more clearly.

25 During this time period we're looking at, 2010

1 to 2017, does the price of OxyContin remain constant?

2 A. I don't know.

3 Q. If we had a chart that showed sales volumes
4 from 2010 to 2017 at Walgreens but measured in dosage
5 units or MME rather than dollars, would the trend look
6 the same?

7 A. Again, I don't know.

8 Q. You mentioned a Walgreens employee named Bob
9 Brody. Do you remember that?

10 A. Yes.

11 Q. Is it your understanding that Mr. Brody was a
12 senior executive at Walgreens?

13 A. No.

14 Q. What was his job as far as you know?

15 A. He was a Walgreens pharmacist. He was a
16 Walgreens pharmacist who became a spokesperson for
17 these superstores.

18 Q. Where was Mr. Brody located?

19 A. I believe Florida.

20 Q. Do you see on page 83, paragraph Roman 12 --

21 A. I'm sorry, your audio --

22 Q. I'm sorry. Do you have in front of you small
23 Roman 12 on page 83 of your report?

24 A. Yes.

25 Q. And there you write "Walgreens pharmacist

1 Brody's protocol recommendations included, quote, the
2 24-hour stores increase their narcotic inventory as
3 much as eight-fold to cover each area."

4 Do you see that?

5 A. Yes.

6 Q. Did you mean to imply there that Mr. Brody
7 recommended that all Walgreens 24-hour stores should
8 increase their inventory this way?

9 A. Well, I don't know if he was including all
10 stores, but he was certainly including some stores, and
11 this as a kind of general strategy.

12 Q. When you decided what parts of this document
13 to quote in your report, you did not intend to be
14 misleading, did you? I assume not.

15 A. No.

16 Q. How many of these superstores did Mr. Brody
17 open up?

18 A. I don't know if any superstores were actually
19 opened up, but it's more the point here that this was a
20 strategy that was being considered by Walgreens.

21 Q. Was this strategy being considered by anybody
22 else at Walgreens other than Mr. Brody?

23 A. Well, according to a November 1999 Purdue
24 memorandum, Bob Brody's plan to promote OxyContin was
25 successfully implemented by Walgreens, including

1 continuing medical education presentations to
2 pharmacists in which Bob Brody was an invited speaker.
3 So he was, in a sense, representing Walgreens at this
4 continuing medical education conference.

5 Q. My question, Doctor -- I think you may have
6 lost sight of the question. My question was, was
7 Mr. Brody's superstore strategy, as you called it, was
8 it being considered by anybody at Walgreens other than
9 Mr. Brody?

10 A. Well, Mr. Brody was a Walgreens pharmacist --

11 Q. Anybody else?

12 A. What's that?

13 Q. I said Mr. Brody was a Walgreens pharmacist.
14 That's one person. Do we have anybody else we can pin
15 this on?

16 MR. ARBITBLIT: Object to form.

17 THE WITNESS: I don't see anything else
18 in my report to that effect.

19 BY MR. STOFFELMAYR:

20 Q. You said you reviewed thousands of documents;
21 is that correct?

22 A. Yes.

23 Q. That includes thousands of internal Purdue
24 documents and thousands of internal Walgreens
25 documents?

1 MR. ARBITBLIT: Object to form.

2 THE WITNESS: I've reviewed thousands of
3 documents. I couldn't parse out how many for each
4 individual defendant.

5 BY MR. STOFFELMAYR:

6 Q. But you certainly reviewed the internal
7 documents from Purdue and Walgreens that Counsel gave
8 to you and suggested that you review?

9 A. Yes.

10 Q. And in all of those Purdue and Walgreens
11 internal documents, did you see any reference to
12 Mr. Brody's superstore strategy, as you called it,
13 anywhere in Ohio or anywhere else besides Florida?

14 A. Only in the documents cited in my report.

15 Q. And the documents cited, as we've discussed,
16 was limited to Mr. Brody's comments in Florida,
17 correct?

18 A. Yes.

19 Q. You mentioned --

20 A. Sorry, your audio cut out.

21 Q. I'm sorry. When I look down at my notes, I
22 apologize.

23 You mentioned a couple of times during your
24 testimony an email from a Walgreens pharmacist named
25 Yaeger, I think. Do you recall that?

1 A. Yes.

2 Q. Where was pharmacist Yaeger located?

3 A. I believe it was Michigan.

4 Q. Do you think it might have been California?

5 A. Let me take a look. It's not in my report and
6 I'm not remembering, but if you represent to me that
7 it's California, I'll believe that it's California.

8 Q. As far as you know, anyway, Mr. Yaeger was not
9 located in Ohio.

10 A. That's correct.

11 Q. And the document you cite is a document in
12 which Mr. Yaeger emails his concerns to a senior person
13 at Walgreens, correct?

14 A. Yes.

15 Q. And the email is then forwarded further inside
16 the Walgreens organization, correct?

17 A. Yes, I believe so.

18 Q. Other than the document you cite, did you
19 review any other documents about what happened next at
20 Walgreens, how this complaint was investigated, what
21 they concluded, anything like that?

22 A. No.

23 Q. Why not?

24 A. Limited time, lots of documents. I'm happy to
25 review that, if you'd like me to.

1 Q. We're not going to have time today, but I do
2 appreciate that.

3 How did you come across this email from
4 Mr. Yaeger to other folks at Walgreens?

5 A. This was provided me by Counsel.

6 Q. Did Counsel provide you with any other
7 documents describing how Mr. Yaeger's complaint was
8 investigated and what steps were taken or what
9 conclusions were drawn?

10 A. No.

11 Q. Did Counsel provide you with any Purdue
12 documents in which people at Purdue were unhappy about
13 their inability to get access to Walgreens pharmacists?

14 A. I believe I have seen such documents, yes.

15 Q. Did you see documents where people at
16 Walgreens -- excuse me, strike that. I'll start over.

17 Did you see documents where people at Purdue
18 were unhappy that Walgreens' pharmacists were refusing
19 to fill prescriptions for OxyContin?

20 A. I have seen documents where Purdue expressed
21 dismay about certain pharmacies that were, in their
22 words, overly concerned with DEA regulations. I'm not
23 now recalling which pharmacies those were or where they
24 were located, but I have seen these types of documents.

25 Q. Did you see Purdue documents where people at

1 Purdue were unhappy that they thought Walgreens
2 policies were too restrictive about dispensing opioid
3 medications?

4 A. Yes, I have seen those types of documents.

5 Q. I'm going --

6 A. I'm sorry, when you --

7 Q. I'm going to switch gears again to something
8 completely different.

9 Appendix 1 to your report includes a list of
10 misleading promotional messages, correct?

11 A. Yes.

12 Q. And there are five parts. You describe
13 misleading promotional messages by a company called
14 Purdue Pharma, by companies called Teva and Cephalon,
15 by Janssen, by Endo, and by Allergan, correct?

16 A. Yes.

17 Q. And all told, Appendix 1 to your report is,
18 give or take, 40 pages, single-spaced, quoting the
19 misleading statements they made and providing your
20 commentary on why you believe they're misleading?

21 A. I haven't counted the pages, but if you did, I
22 will accept that.

23 Q. 40 pages doesn't sound out of the ballpark?

24 A. No.

25 Q. And in prior reports, you also included

1 misleading statements by a company called Mallinckrodt.

2 A. Yes.

3 (Reporter clarification.)

4 Q. Mallinckrodt. I can spell it for you off the
5 record.

6 Let me ask the question again, Doctor, just so
7 we're not interrupted.

8 In prior expert reports, you've also provided
9 a list of misleading statements by a company called
10 Mallinckrodt, correct?

11 A. Yes.

12 Q. Why did you not include the Mallinckrodt
13 misleading statements in this report?

14 A. As I'm recollecting now, these various opioid
15 manufacturer entities have gone by different names with
16 a very complex transition from one LLC to another. It
17 could be that Mallinckrodt is included under a
18 different name here. I'm not exactly remembering why
19 Mallinckrodt is no longer in the appendix specifically
20 under that name.

21 Q. To be -- strike that.

22 If it turns out to be the case, and I'll tell
23 you that it is, but you can confirm this yourself
24 later, if it turns out that Mallinckrodt is independent
25 of the five companies you list in Appendix 1 to your

1 report here, for the sake of completeness, would it
2 make sense to take the Mallinckrodt misleading
3 statements and add them to the five companies you have
4 in your Appendix 1 to your report?

5 A. So this report has gone through various
6 iterations over time depending upon who the defendants
7 are and what additional material I have reviewed. So I
8 wouldn't want to say yay or nay to whether or not
9 Mallinckrodt being included here in this case makes
10 sense. I'm not recalling -- if they were removed from
11 a prior report, I'm not recalling why.

12 Q. Let me ask it this way: You haven't changed
13 your mind about Mallinckrodt's misleading statements,
14 about your prior reports and Mallinckrodt's misleading
15 statements, you haven't changed your mind about that?

16 A. I haven't changed my mind, no.

17 Q. In none of your reports in any of the lawsuits
18 where you've given a report, have you included a
19 similar appendix with a list of misleading promotional
20 messages by pharmacy chains, correct?

21 MR. ARBITBLIT: Object to form.

22 THE WITNESS: I do have a pharmacy
23 specific section of my report. I did debate with
24 myself whether or not it would make sense to include it
25 in the body of the report or to make a separate

1 appendix and ultimately decided I would include it in
2 the body of the report.

3 BY MR. STOFFELMAYR:

4 Q. If we asked you to, you could do an appendix
5 like that, correct, where we could look at what you
6 think are the misleading promotional statements by
7 pharmacy chains?

8 A. I mean I could do that. You know, I think
9 the -- the -- the key to the pharmacy chains'
10 collaboration in those false and misleading messages
11 was the way in which they collaborated with opioid
12 manufacturers and other entities in medicine.

13 Q. But to be clear about the answer to my
14 question, if you wanted to, you could do a similar
15 appendix with a list of misleading promotional messages
16 by each pharmacy chain, that is something you would be
17 able to do?

18 A. Probably, yes.

19 Q. Last couple of questions, you understand that
20 this case is set to go to trial in Cleveland in
21 October, correct?

22 A. Yes.

23 Q. And if the plaintiffs' lawyers ask you to, do
24 you intend to come to Cleveland and testify in front of
25 the jury?

1 A. Yes.

2 Q. If the defendants' ask you and buy you a plane
3 ticket, would you come at our request as well?

4 A. I'm not sure I'm understanding your question.

5 Q. If I sent you an email or sent Mr. Arbitblit
6 an email and said we would like Dr. Lembke to come
7 Cleveland to testify in front of the jury, we'll pay
8 for her plane ticket, would you agree to do that?

9 MR. ARBITBLIT: Objection --

10 THE WITNESS: Yes.

11 MR. STOFFELMAYR: Thank you.

12 Dr. Lembke, thank you so much for your time.
13 I know it's Friday afternoon. I will sit down now and
14 let the others ask questions so we can all -- I won't
15 say go home because some of us are already home, but
16 get to wherever we would rather be.

17 MR. ARBITBLIT: So before you switch to
18 another Counsel, we've been going for about 70 minutes,
19 let's take our last break.

20 THE VIDEOGRAPHER: We are going off the
21 record at 2:50.

22 (Recess taken 2:50 p.m. to 3:01 p.m.)

23 THE VIDEOGRAPHER: We are back on the
24 record. The time is 3:01, please proceed.

25

1 EXAMINATION

2 BY MR. CARTER:

3 Q. Good afternoon, Dr. Lembke. Are you okay to
4 continue?

5 A. Yes, I am.

6 Q. We've met before, but my name is Ed Carter,
7 and I represent Walmart, and I have a few questions for
8 you today, all right?

9 A. Okay.

10 Q. I want to start with a logistics question.
11 What did you bring with you to the deposition today?

12 A. I have a paper copy of my report, and I have
13 the document --

14 Q. Do you have any other?

15 A. I have the document --

16 Q. Sorry, go ahead.

17 A. I have the documents that defendant sent to
18 me.

19 Q. Any other materials with you in the room?

20 A. No.

21 Q. Well, and you do have a copy of your book,
22 correct?

23 A. Yes.

24 Q. And book, exhibits, that we sent, and a paper
25 copy of your report; that's everything, correct?

1 A. Yes.

2 Q. Does your paper copy of your report have notes
3 or margin area?

4 A. It has post-its to serve as an index so I can
5 try to find things more quickly.

6 Q. Anything other than post-its?

7 A. No.

8 Q. All right. Switching gears, did any pharmacy
9 in Lake or Trumbull County conduct itself in a way that
10 you consider to be compliant with best practices in the
11 requirements under the Controlled Substances Act?

12 MR. ARBITBLIT: Object to form.

13 THE WITNESS: Again, my opinions on Lake
14 and Trumbull County are based on my review of national
15 policies of the defendants' policies and procedures,
16 and so my opinion of those policies and procedures for
17 good and for bad are the same nationally as they are in
18 Lake and Trumbull County because I have no evidence to
19 suggest that Lake and Trumbull County are outliers.

20 BY MR. CARTER:

21 Q. So with respect to the defendant pharmacies
22 named in this case, is it your opinion that every
23 pharmacy location for one of the defendant pharmacies
24 in Lake or Trumbull County was acting in a
25 non-compliant way?

1 A. My opinion is not based on every pharmacy or
2 every pharmacist. My opinion is looking at the
3 aggregate evidence to determine what the policies and
4 procedures were in defendant chains' pharmacies and to
5 form my opinion based on that.

6 Q. Did you conduct any systematic review of the
7 defendant pharmacies in Lake or Trumbull County to
8 identify the good pharmacy locations and distinguish
9 them from bad pharmacy locations?

10 MR. ARBITBLIT: Object to form.

11 THE WITNESS: So my systematic review is
12 my report and my opinion is based on aggregate data,
13 and Trumbull and Lake Counties are not, in my opinion,
14 outliers for what was happening nationally.

15 BY MR. CARTER:

16 Q. Is there any county in the country that you
17 would identify as an outlier from the national pattern?

18 A. Opioid prescribing patterns suggest that there
19 are counties in the country that were more affected by
20 the oversupply of opioids than others, but that the
21 problem extended to everywhere in the United States,
22 that it wasn't localized to any specific state or
23 region, although clearly, there are differences,
24 geographic differences in the severity of the opioid
25 epidemic region to region.

1 Q. And what are -- what differences, if any, were
2 there in Lake and Trumbull County in terms of the
3 degree of severity?

4 A. The degree of severity in Lake and Trumbull
5 County is generally consistent with national trends.

6 Q. And so how would you describe it in a
7 quantitative way?

8 A. Can you give me a moment to look at my report?

9 Q. Sure.

10 A. So on page 3 of Appendix 3, I've included a
11 table that shows national opioid prescribing trends per
12 100 persons in the United States compared to the state
13 of Ohio, compared to Lake County, and compared to
14 Trumbull County. And as you can see, the number of
15 prescriptions written per 100 persons between 2006 and
16 2019 in Lake County is consistent with the numbers
17 written nationally, although the peak in Lake County in
18 2012 --

19 (Reporter clarification.)

20 A. -- was 90.2 prescriptions written per 100
21 persons compared to 81.3 prescriptions per 100 persons
22 written in the United States generally.

23 If you look at Trumbull County, you'll see
24 that the Trumbull County averages are higher than
25 national averages starting in 2006 and peaking in 2010

1 at 114 prescriptions per 100 persons, and then
2 decreasing to national averages by 2019.

3 I have other data in this specific location
4 appendix detailing prescription opioid overdose deaths
5 in Lake County and Trumbull County as well as Ohio
6 overall. And what you can see on page 4 in Figure 5 is
7 that unintentional fatal drug poisoning rates and
8 distribution rates of prescription opioids in grams per
9 100,000 population by year in Ohio went up between 1997
10 and 2007. And again, those are roughly consistent with
11 national trends, or really even higher, but roughly a
12 quadrupling of opioid-related -- or drug poisoning
13 overdose deaths, opioid-related overdose deaths between
14 the late 1990s and approximately 2007.

15 Q. So with the chart on page 3 that indicates the
16 prescribing rates, do you -- did you analyze that
17 against the rate within either Lake or Trumbull County
18 at which there was evidence-based, legitimate
19 prescribing of opioid medications?

20 MR. ARBITBLIT: Object to form.

21 THE WITNESS: Yeah, I can't answer your
22 question because of the way it's formulated.

23 BY MR. CARTER:

24 Q. Let me try a simple example using the chart
25 and maybe that will make more sense. If you look at

1 2006, the first line of data on page 3 of Appendix 3,
2 you see the prescribing rate per 100 persons in Lake
3 County is listed as 72.3, correct?

4 A. Are we back to page 3? I'm sorry, say that
5 again what year?

6 Q. Yes. For the first year in the chart, 2006,
7 the data point for Lake County is 72.3, correct?

8 A. Yes.

9 Q. Do you know what number or percentage of that
10 72.3 represents evidence-based, legitimate prescribing?

11 A. Well, it is my opinion that any increase prior
12 to late 1990s in opioid prescribing is probably not
13 legitimate opioid prescribing because it's contrary to
14 the evidence showing that the risks of prescribing at
15 higher doses for longer duration outweigh the benefits.
16 So given that there is --

17 Q. So -- I'm sorry, go ahead.

18 A. Yeah, I was just going to say the -- there is
19 no explanation for the increase in prescribing in Lake
20 County over that time period except for the promotional
21 strategies and the increased supply.

22 Q. So if I'm understanding you correctly, is it
23 your testimony that if we went back and pulled an
24 equivalent data point for Lake County from the late
25 1990s before the increase in messaging and used that as

1 a baseline, that the prescribing rate per 100 persons
2 up to that baseline would be consistent with
3 evidence-based, legitimate prescribing?

4 A. So that's overstating my testimony, because
5 it's -- my testimony is based on aggregate, and
6 everything I've looked at and the sudden increase in
7 prescribing and the supply, it's not to say that every
8 single prescription prior to that sudden increase was a
9 legitimate prescription.

10 Q. So in 1990, to the extent an opioid was
11 prescribed in Lake County, is it your testimony that
12 there was illegitimate prescription for opioid
13 medications in Lake County in 1990?

14 A. So I think ever since opioids have been around
15 and prescribed by doctors and dispensed, there have
16 been instances of illegitimate prescribing and
17 dispensing, but I think the fraction was much, much
18 smaller prior to the paradigm shift that started in the
19 late 1990s.

20 Q. So looking back at this 2006 data point for
21 Lake County that we were discussing, the 72.3, is it
22 your testimony that 100 percent of that 72.3 is not
23 evidence-based, legitimate medical prescribing?

24 A. No.

25 Q. So some portion of that would be

1 evidence-based, legitimate medical prescribing, but
2 you're not able to put a specific number on it; is that
3 a fair understanding of your testimony with respect to
4 that data point?

5 MR. ARBITBLIT: Object to form.

6 THE WITNESS: Well, what I've -- what
7 I've said before, and I'll try to say it again is that
8 the difference between the 2006 rates of prescribing
9 and the prescribing that existed prior to, say, 1996,
10 that through that change, a much higher percentage of
11 the prescribing was not for a legitimate medical
12 purpose.

13 BY MR. CARTER:

14 Q. Are you able to identify -- well, strike that.
15 Have you conducted an analysis of the
16 prescribing in Lake County to enable you to identify a
17 specific number or a specific percentage of the
18 prescriptions there that were evidence-based,
19 legitimate prescriptions?

20 A. I think the analysis can be inferred from the
21 CDC data showing that as the number of prescriptions
22 quadrupled between the late 1990s and the mid-2007 time
23 frame, 2012 time frame, since so many people were dying
24 from prescription opioids, I think it is safe to infer
25 that a large percentage of individuals who died were

1 not receiving opioids for a legitimate medical purpose.

2 Q. Now, you just described that as a "large
3 percentage." Are you able to put a specific number to
4 it?

5 A. Again, I would say that the quadrupling
6 between -- times four from the late 1990s to the peak,
7 which is around 2011, 2012, would be the increased
8 number that is not explained by legitimate medical
9 condition.

10 Q. All right. I want to jump through to the
11 bottom of the chart on page 3 and look at the same
12 Column 43.1 for 2019.

13 Do you see that?

14 A. Yes.

15 Q. Is that 43.1 prescribing rate, does that
16 represent evidence-based, legitimate medical
17 prescriptions for opioids in Lake County?

18 MR. ARBITBLIT: Object to form.

19 THE WITNESS: So this table starts at
20 2006. It doesn't include information from the late
21 1990s up through 2006. And in general, what national
22 trends show is that although prescribing -- opioid
23 prescribing has decreased since its peak around 2012,
24 it's still higher than the late 1990s levels, implying
25 that a significant percentage of that 43.1 is, let's

1 say, legacy prescribing in addition to not prescribing
2 for a legitimate medical condition. And I'm happy to
3 explain that further if it would be helpful.

4 BY MR. CARTER:

5 Q. Compassionate prescribing to titrate users
6 with dependence, that would be considered a legitimate
7 prescribing practice from your perspective, correct?

8 A. Well, I wouldn't use the word "titrate," I
9 would use the word taper. But yes, compassionate
10 tapering would be a legitimate use.

11 Q. Now, I pulled out, for exemplar purposes, the
12 2006 data for Lake County, and the 2019 data for Lake
13 County, if I asked you the same questions for Trumbull
14 County would you provide the same answers in terms of
15 reference to the testimony and the data?

16 A. Yes.

17 Q. And would you provide the same answer if I
18 picked out any of those years in this chart on page 3
19 of Appendix 3?

20 MR. ARBITBLIT: Objection to form.
21 Vague.

22 THE WITNESS: Yes.

23 BY MR. CARTER:

24 Q. All right. So putting the chart aside, in
25 your expert opinion, what is the appropriate level of

1 evidence-based opioid prescribing that would be
2 legitimate for Lake County for any year?

3 MR. ARBITBLIT: Object to form. Asked
4 and answered.

5 THE WITNESS: Yes, I do feel I answered
6 that. Is there something different or more that you
7 would like from me?

8 BY MR. CARTER:

9 Q. I'm asking if you could put a prescribing rate
10 per hundred or a percentage or a volume, a quantitative
11 response to what you believe is an appropriate
12 evidence-based, legitimate level of prescribing for
13 Lake County.

14 A. I think legitimate, evidence-based prescribing
15 has to include both quantitative and qualitative
16 assessments. Quantitatively, as I've said before, per
17 person I believe that we need to reduce prescribing
18 back to the pre-1996 levels, and then qualitatively,
19 it's important that opioid prescribing be
20 evidence-based.

21 Q. Would you provide the same answer for Trumbull
22 County?

23 A. Yes.

24 Q. And is that your best answer for both
25 counties?

1 A. Yes.

2 Q. Thank you.

3 I want to ask you about pharmacies in Lake
4 County that are not operated by one of the defendant
5 chains in this case, so non-defendant pharmacies. Have
6 you conducted any systematic analysis of the policies,
7 practices related to dispensing of any non-defendant
8 pharmacy in Lake County?

9 A. Again, my assessment is an aggregate looking
10 at national chain policies. I have no reason to
11 believe that pharmacies in Lake and Trumbull County are
12 exempt from that, including pharmacies that are not
13 named in this case.

14 Q. So can you identify for me any pharmacy that
15 is not a defendant in this case for which you have
16 analyzed, on a national level, their policies,
17 procedures, training related to dispensing of opioid
18 medications?

19 A. I have focused on the pharmacies that are
20 named as defendants in this case.

21 Q. You say you've focused on them. Have you
22 conducted a systematic analysis on a national basis of
23 any pharmacy that is not Giant Eagle, Rite Aid,
24 Walmart, Walgreens, or CVS?

25 A. No.

1 Q. So sitting here today, are you able to compare
2 how the policies related to dispensing opioids of the
3 defendants in this case compare to any other pharmacy
4 across the nation?

5 A. No.

6 Q. Similar question, are you able to compare the
7 policies related to pharmacist training of any of the
8 pharmacy defendants in this case to any other
9 non-defendant pharmacy across the nation?

10 A. No.

11 Q. In terms of guidance provided to pharmacists
12 related to their exercise of corresponding
13 responsibility, are you able to compare the policies
14 and practices of any of the pharmacy defendants in this
15 case to any other pharmacy across the nation?

16 A. No.

17 Q. Same question for policies related to
18 investigation and due diligence on red flags, are you
19 able to compare any of the policies that the pharmacies
20 in this case had over time to any other pharmacy across
21 the nation?

22 A. Well, I have looked at DEA enforcement
23 regulations, which do include pharmacies that are not
24 part of defendant pharmacies. Giant Eagle Pharmacy, I
25 believe is not one of the defendant pharmacies. Sorry,

1 not Giant Eagle. I misspoke. Wait a moment, please.
2 Sorry, the East Main Street Pharmacy in Ohio.

3 Q. And you cited that DEA Enforcement Action and
4 order in your report, correct?

5 A. What do you mean "in order"?

6 Q. I said you cited the DEA suspension order in
7 your expert report for this case, correct?

8 A. Yes, I did. Page 106.

9 Q. All right. Other than East Main Street
10 Pharmacy, is there any other non-defendant pharmacy
11 across the nation where you have familiarity with their
12 policies related to red flag investigation and due
13 diligence?

14 A. Yes, on page 107, I talk about a Zion Clinic
15 Pharmacy that was the subject --

16 Q. I'm sorry, go ahead.

17 A. That was the subject of DEA action.

18 Q. And so for East Main Street Pharmacy and Zion
19 Pharmacy, other than reading the DEA Enforcement
20 Action, did you actually go to the primary sources and
21 pull policies for either of those pharmacies for
22 purposes of your analysis?

23 A. No.

24 Q. Sitting here today, do you know one way or
25 another whether any of the non-defendant pharmacies in

1 Lake County performed their dispensing duties at a
2 level that you would judge to be compliant with best
3 practices in the CSA?

4 MR. ARBITBLIT: Object to form.

5 THE WITNESS: I did not specifically
6 look at non-defendant pharmacies outside of East Main
7 Street Clinic and Zion Clinic Pharmacies.

8 BY MR. CARTER:

9 Q. So same question for Trumbull County?

10 A. Yes.

11 Q. Same answer?

12 A. Yes.

13 Q. I want to ask you a broader question. Do you
14 agree that most pharmacists across the country try to
15 do the right thing in dispensing medications to
16 patients?

17 MR. ARBITBLIT: Object to form.

18 THE WITNESS: I believe that the systems
19 under which most pharmacies -- most pharmacists have
20 been working in defendant pharmacy chains have made it
21 impossible for them to do the right thing.

22 BY MR. CARTER:

23 Q. So my question is broader, and I'm asking
24 irrespective of the defendant pharmacies, as a
25 practice, is it your opinion that most pharmacists

1 across the country working in every pharmacy in the
2 country, that most of them are trying to do the right
3 thing by their patients?

4 MR. ARBITBLIT: Object to form.

5 THE WITNESS: I would -- I would say
6 that most of them are trying to do the right thing,
7 yes.

8 BY MR. CARTER:

9 Q. And with respect to the chain defendant
10 pharmacies in this case, do you agree that most of the
11 pharmacists working for the chain defendants try to do
12 the right thing?

13 MR. ARBITBLIT: Object to form.

14 THE WITNESS: Yes.

15 BY MR. CARTER:

16 Q. When were you retained to perform your work
17 for this case?

18 A. I was retained by the MDL in 2017.

19 Q. When were you first given the assignment that
20 you answered with your report for this case, track
21 three case?

22 A. 2017. I mean the original MDL included
23 manufacturers, distributors, and pharmacies.

24 Q. Okay, so the first time you were asked to
25 assess whether the pharmacies played a role in

1 contributing to an opioid crisis, that was in 2017?

2 A. My focus at that point was not the pharmacies.
3 I had not yet had a chance to review the internal
4 documents that I later had the opportunity to review
5 that allowed me to form an opinion about defendant
6 pharmacies.

7 Q. When was the first point in time when you
8 started the process of focusing on the pharmacies?

9 A. I'm not remembering specifically. I've been
10 working on this case for a number of years now and I
11 don't remember exactly when my focus on the pharmacies
12 began.

13 Q. If we looked at the invoices that you've
14 produced for this case track three, would that reflect
15 the entirety of the work that you've performed on this
16 specific case track?

17 A. Probably not the entirety because I was
18 probably reviewing documents relating to pharmacies
19 prior to that.

20 Q. Okay. Exhibit B to your report includes
21 materials considered, and we received a supplemental
22 list of materials considered last night. Combining
23 those two lists, is that the full universe of materials
24 that you've considered for purposes of this expert
25 report?

1 A. Yes.

2 Q. I'll represent to you that on Exhibit B there
3 are two dozen documents that Walmart produced bearing
4 Walmart's Bates numbers. Does that sound correct to
5 you? If you're looking at Exhibit B, it's page 88.

6 A. Yes.

7 Q. All right. Was it your intention to identify
8 in Exhibit B all of the Walmart produced documents that
9 you considered for purposes of this case?

10 A. Those documents in Exhibit B plus the other
11 documents that I reviewed, again, including DEA
12 actions, the medical literature, everything that I've
13 cited here is what I used in forming my opinion.

14 Q. All right. And so for the documents that were
15 produced by Walmart, entries 1740 through 1763 in
16 Exhibit B, do you see that?

17 A. Yes.

18 Q. How did you identify and select those Walmart
19 documents for purposes of your methodology in this
20 case?

21 A. Those documents were provided me by Counsel,
22 and after reviewing, if I had further questions or
23 wanted further documents, I asked for them and then
24 additional documents were provided when available.

25 Q. Did you request any Walmart produced documents

1 that were not provided to you?

2 A. Yes.

3 Q. What Walmart documents did you ask for that
4 you did not receive in response?

5 A. I would have liked to have looked at the
6 specific notes by pharmacists around how they handled
7 red flags.

8 Q. Anything else?

9 A. That's the main one.

10 Q. Do you think that 24 documents is a sufficient
11 sample size for a review of Walmart's dispensing
12 policies from the time period of 2006 through to today?

13 A. I do believe that those documents in
14 combination with the other documents that I've reviewed
15 were sufficient, yes.

16 Q. Included in the documents that you listed in
17 Exhibit B are pharmacy operations manuals or POMs. Do
18 you recall that?

19 A. Yes.

20 Q. Do you know how many POMs you included in
21 Exhibit B?

22 A. I believe 3 or 4. I'm not remembering right
23 now.

24 Q. Do you know how many POMs Walmart had that
25 impact the area of dispensing?

1 A. No.

2 Q. If I represented to you that Walmart had more
3 than 50 POMs, do you agree that reviewing 3 or 4 out of
4 50 POMs is not a systematic review of the pharmacy
5 operations manual?

6 MR. ARBITBLIT: Object to form.

7 THE WITNESS: No, I don't agree.

8 BY MR. CARTER:

9 Q. So it's your testimony to the jury that it's
10 possible to get a systematic analysis of Walmart's
11 pharmacy operations manual by reviewing 3 or 4 of the
12 POMs?

13 MR. ARBITBLIT: Object to form.

14 Misstates.

15 THE WITNESS: Again, those POMs were not
16 reviewed in isolation. I reviewed those in the broader
17 context of many other documents about Walmart's
18 practices and policies.

19 BY MR. CARTER:

20 Q. But those many other documents did not include
21 approximately four dozen additional POMs, correct?

22 A. I reviewed the Department of Justice 2020
23 report, as well as various DEA reports, which may have
24 well included the review of POMs.

25 Q. Putting aside reading the work of others, did

1 you yourself set out to conduct a systematic review of
2 Walmart's dispensing policies?

3 MR. ARBITBLIT: Object to form.

4 THE WITNESS: I believe that I reviewed
5 a sufficient amount of material to form an opinion on
6 Walmart's dispensing policies.

7 BY MR. CARTER:

8 Q. You mentioned the 2020 DOJ report. Are you
9 referring to the lawsuit that DOJ filed against Walmart
10 in Delaware?

11 A. Yes.

12 Q. Do you understand -- well, strike that.

13 Did you ask for and review Walmart's answer to
14 that complaint?

15 A. Yes.

16 Q. And did you conduct a systematic comparison
17 between the allegations in the complaint and Walmart's
18 response and the answer?

19 A. I believe so, yes.

20 Q. Did you ask for copies of any of the exhibits
21 or policies or documents that were cited in Walmart's
22 answer to the complaint?

23 A. I'm not remembering a specific document, but
24 it's likely that I reviewed some of the documents cited
25 in the Walmart complaint.

1 Q. And just to be clear, I'm asking you about
2 Walmart's answer to DOJ's complaints; do you
3 understand?

4 A. Walmart's answer, yes.

5 Q. Would you agree it would be -- it would be
6 highly improper to base your opinions simply on a
7 complaint filed by one party in a lawsuit without
8 looking at the full facts; fair?

9 MR. ARBITBLIT: Object to form.

10 THE WITNESS: I do think I looked at the
11 full facts.

12 BY MR. CARTER:

13 Q. Right, and I'm not asking you what you looked
14 at at this point because you've already told me that.
15 I'm asking you do you agree that merely looking at the
16 complaint without looking at the full facts, that would
17 be a problematic expert method?

18 A. Well, the complaint was very thorough but,
19 yes, I agree it would be good to look at multiple
20 documents.

21 Q. To the extent you quote from the DOJ's
22 complaint in your expert report, do you agree that if
23 Walmart wins that case in front of a jury, that the
24 quotations from the DOJ's complaint would be
25 invalidated?

1 MR. ARBITBLIT: Objection. Speculative.

2 THE WITNESS: Based on my review, I
3 don't believe that that would be invalidated, no.

4 BY MR. CARTER:

5 Q. So if a jury disagreed with the DOJ's
6 complaint, would you accept that jury's determination?

7 MR. ARBITBLIT: Object to form.

8 THE WITNESS: What do you mean by
9 "accept that determination"?

10 BY MR. CARTER:

11 Q. So if the DOJ case is litigated before this
12 case and the jury sides with Walmart in the DOJ
13 complaint, would you amend or retract your reliance on
14 the DOJ's complaint for your report in this case?

15 MR. ARBITBLIT: Object to form.

16 THE WITNESS: Whether or not I relied on
17 the DOJ report in this case, my opinion is unchanged.

18 BY MR. CARTER:

19 Q. For all of the portions in your report where
20 you have quoted from the DOJ's complaint against
21 Walmart, did you conduct any independent analysis to
22 verify or corroborate what you've quoted in your report
23 from the DOJ?

24 A. Yes, I did additional analysis to verify.

25 Q. All right. Switching gears, when was there a

1 medical consensus that prescription opioids were a
2 cause of increased abuse, overdose, and mortality?

3 A. I would say that that consensus emerged
4 slowly, probably beginning around 2011 when the CDC
5 said that we were in the midst of a prescription drug
6 epidemic, but I would say even then many prescribers
7 remained unaware of the extent to which their own
8 prescribing was contributing to the epidemic. Probably
9 wasn't until 2016 with the publication of the CDC
10 guidelines that there was broad awareness.

11 Q. You indicated in response to questioning from
12 Mr. Gisleson that your own personal evolution was
13 something that occurred in the 2000s. Is there a
14 particular point in time by which you can definitively
15 say that you, Dr. Anna Lembke, were aware of the role
16 of opioid medications in abuse, addiction, and
17 mortality?

18 MR. ARBITBLIT: Objection. Form.

19 THE WITNESS: I would say it was an
20 iterative process that occurred over time. There
21 wasn't a single moment in time where I became aware.

22 BY MR. CARTER:

23 Q. And I appreciate that. Was there a point in
24 time by which you can say definitively you had that
25 awareness? I mean, by the time you wrote your book,

1 for example, you were aware of that, correct?

2 A. Yes.

3 Q. Was there a date prior to the publication of
4 your book by which you would be comfortable saying that
5 iterative process had run its course?

6 A. Probably about 2013, 2014.

7 Q. I want to ask you about page 108 of your
8 report, romanette -- in section I, romanette I. I
9 guess that would be romanette 1, sorry. Tell me when
10 you're there.

11 A. Okay, I'm there.

12 Q. All right, so in romanette 1 you wrote, "By
13 2005, the prescription opioid epidemic was several
14 years into its evolution, having begun in the mid to
15 late 1990s. As you recounted previously in this
16 report, the medical literature, CDC data, and articles
17 in the lay press had made clear that prescription
18 opioids were the cause of a significant spike in
19 overdose and mortality."

20 Did I read that correctly?

21 A. Yes.

22 Q. I want to ask you about that last sentence.
23 To the extent the medical literature, the CDC data, and
24 articles in the lay press had made clear that
25 prescription opioids were the cause of a significant

1 spike in overdose and mortality, is that something that
2 you yourself, Dr. Lembke, were aware of by 2005?

3 A. No.

4 Q. And that was before the time period that you
5 testified earlier by which you would agree there was a
6 scientific and medical consensus to that effect,
7 correct?

8 A. I'm sorry. What testimony are you referring
9 to?

10 Q. Strike that. I'll ask a cleaner question.

11 Is it your opinion in this paragraph,
12 romanette 1, that Walmart should have known in 2005
13 something that you yourself, as a physician from
14 Stanford, did not understand?

15 A. Yes.

16 Q. Is it your testimony that pharmacists working
17 in Lake or Trumbull County should have understood, in
18 2005, something that you yourself did not understand?

19 MR. ARBITBLIT: Object to form.

20 THE WITNESS: I think that the
21 pharmacies had access to information that I as an
22 individual prescriber did not have, and therefore,
23 would have and could have known earlier than I could
24 have known.

25

1 BY MR. CARTER:

2 Q. Now, you cite in this section as well as
3 previously, the East Main Street case that we
4 discussed, correct?

5 A. Yes.

6 Q. Now, you note in footnote 530 at the bottom of
7 this page that the affirmants of suspension order was
8 published on October 27, 2010, correct?

9 A. Yes.

10 Q. You include a parenthetical to indicate that
11 it was describing misconduct in 2005 and 2006 as the
12 basis for the DEA enforcement, correct?

13 A. Yes.

14 Q. You understand that Walmart and the other
15 pharmacy defendants would not have been privy to a DEA
16 enforcement action prior to its publication in October
17 of 2010, correct?

18 A. Yes, that makes sense.

19 Q. So you don't mean to be suggesting by this
20 section of your report that the pharmacies were on
21 notice in 2005 that the DEA was investigating East Main
22 Street pharmacy in Columbus, Ohio, are you?

23 A. Specifically the East Main Street example, no.

24 Q. Do you know what the typical timeline is for a
25 DEA investigation of a pharmacy? Is this approximately

1 four-year period on the East Main Street case, is that
2 a typical timeline for a DEA action?

3 A. I don't know.

4 Q. Now, I want to continue on the same page to
5 romanette 2. You reference Section 1703 of Walmart's
6 pharmacy operations manual. Do you see that?

7 A. Yes.

8 Q. Now, that section was titled and dealt with
9 "Forged and Altered Prescriptions," correct, at least
10 in the 2005 edition?

11 A. Give me a moment. Yes.

12 Q. Do you have any evidence that Walmart in Lake
13 or Trumbull County -- well, strike that.

14 Do you have any evidence that Walmart
15 pharmacists in Lake or Trumbull County filled
16 improperly a forged or altered prescription?

17 A. Again, I have no evidence to the contrary.

18 Q. You've said that a couple times that you have
19 no evidence to the contrary. Did you look for evidence
20 to see whether the POM actually worked one way or the
21 other?

22 MR. ARBITBLIT: Object to form.

23 THE WITNESS: I did request the pharmacy
24 notes.

25

1 BY MR. CARTER:

2 Q. Why did you request -- why did you request the
3 notes?

4 A. To see specifically what pharmacists
5 identified as red flags and what they didn't identify
6 as red flags and how they investigated those red flags,
7 if they did investigate them.

8 Q. Do you know what the standard nationally was
9 in 2005 for documenting a suspected forged or altered
10 prescription?

11 MR. ARBITBLIT: Object to form.

12 THE WITNESS: I believe that I do, yes.

13 BY MR. CARTER:

14 Q. And what was the standard nationally that
15 applied to pharmacies and pharmacists with respect to
16 forged or altered prescriptions in 2005?

17 A. Looking for different types of handwriting on
18 a prescription, looking for a prescription written with
19 language not consistent with the way that doctors
20 usually write prescriptions, looking for prescriptions
21 that might have been photocopied, looking for
22 prescriptions that might have had things crossed out or
23 edited.

24 Q. And what's the practice if a pharmacist in
25 Lake County was presented with a prescription with one

1 of those criteria in 2005, what were they supposed to
2 do with that prescription?

3 A. As with any red flag, pharmacists would have
4 been required to further investigate before --

5 Q. Would they be required to -- would they be
6 required to confiscate a prescription?

7 A. I'm not sure.

8 Q. Would they be required to write void or some
9 kind of notation on the face of the prescription?

10 A. Yes.

11 Q. And what's your basis for that?

12 A. My study of pharmacy practice, 20-plus years
13 of treating patients, and interacting with pharmacists.

14 Q. And so you're prepared to state the
15 credibility of your testimony that that was a national
16 standard for pharmacists in 2005?

17 MR. ARBITBLIT: Object to form. Excuse
18 me, object to form.

19 THE WITNESS: I'm not saying that that
20 was the national standard in 2005. It's my
21 understanding that that is the national standard, that
22 has been the national standard, and is the standard
23 today.

24 BY MR. CARTER:

25 Q. Was that the standard in Ohio in 2005 at the

1 time of this POM?

2 A. I have no reason to think otherwise.

3 Q. And do you have any evidence that a Walmart
4 pharmacist failed to follow POM 1703 in Lake or
5 Trumbull County?

6 MR. ARBITBLIT: Object to form.

7 THE WITNESS: I have the evidence
8 provided by the DOJ complaint. I have the evidence
9 provided by the DEA citation that Walmart was
10 repeatedly dispensing prescriptions outside of a
11 legitimate medical purpose.

12 BY MR. CARTER:

13 Q. Do either of those two sources contain facts
14 specific to Lake or Trumbull County?

15 A. Not as far as I know.

16 Q. Okay. I want to turn to the next page of your
17 report, page 109, romanette 3. There is a discussion
18 of the 2007 "New York Times" report. Do you see that?

19 A. Yes.

20 Q. And then at the end of that paragraph you
21 conclude, quote, "This widely publicized event gave
22 further notice to pharmacy defendants and to the world
23 at large that OxyContin, a very popular and profitable
24 drug, carried major risks of abuse and that the risks
25 had been downplayed."

1 Did I read that correctly?

2 A. Yes.

3 Q. Was that something that you were aware of in
4 May of 2007?

5 A. I was beginning to be aware, but as I said, it
6 was an evolution, and I wasn't fully aware.

7 Q. I want to ask you a broader question. What
8 was the first year in which the DEA provided a public
9 and official guidance to pharmacists or pharmacies
10 identifying distance traveled as a red flag?

11 A. I don't know.

12 Q. When was the first time the DEA issued public
13 guidance to pharmacies identifying a trinity
14 prescription or combination prescription as a red flag?

15 A. Well, certainly by 2010 with the East Main
16 Street case and probably before then, but I don't know
17 exactly.

18 Q. Same question for cash payments.

19 A. Again, no later than 2010.

20 Q. And then last one in this series, same
21 question for high volume prescribers.

22 A. I'm not sure. I don't know.

23 Q. All right, I want to ask you about romanette 6
24 on page 110 of your report. The romanette starts on
25 page 109, but I want to ask you about the sentence in

1 italics in the middle of that top paragraph on
2 page 110. Let me know when you're there.

3 A. Okay.

4 Q. So in the middle of that paragraph you wrote,
5 "In each example, Walmart's compliance unit knew that
6 its pharmacists were continuing to be presented with
7 prescriptions issued by those prescribers and that
8 based on the reported red flags there was a very high
9 probability that the prescribers were regularly issuing
10 invalid controlled substance prescriptions."

11 Did I read that correctly?

12 A. Yes.

13 Q. Do you know whether any of those prescribers
14 were located in Lake or Trumbull?

15 A. Well, right below that I talk about how one of
16 the examples in that report was a Florida physician
17 whose patients filled prescriptions at Walmart stores
18 in 32 states around the country, including Ohio, and I
19 don't know specifically if it went to pharmacies in
20 Lake and Trumbull County, but could have been.

21 Q. And did any of those physicians, including the
22 one that you identify as an example, were any of them
23 not licensed by the state where they were practicing
24 medicine at the time that they were issuing
25 prescriptions?

1 A. I'm not recalling right now. I do recall in
2 the many documents I have reviewed the pharmacy
3 defendants filling prescriptions for individuals whose
4 DEA licenses had expired, for example, but I'm not
5 recalling if that's specifically true in this case.

6 Q. And in the examples described in romanette 6
7 of your report, were there any prescribers who had DEA
8 registrations that had been revoked?

9 A. I'm not specifically remembering.

10 Q. Let me ask you a broader question to see if I
11 can streamline things. Are you aware of any situation
12 where any pharmacy defendant in Lake or Trumbull County
13 filled a prescription that was written by an unlicensed
14 or unregistered prescriber?

15 A. Again, I don't have any evidence to the
16 contrary. I don't have any specific evidence to that
17 effect, but these were problems that were occurring at
18 Walmart's and Rite Aids and CVSs and the other
19 defendants all around the country.

20 Q. I want to switch gears. You previously
21 testified that because you were part of that generation
22 impacted by the paradigm shift, that you unknowingly
23 and unwittingly wrote prescriptions that would have
24 been diverted by patients; is that correct?

25 A. Yes.

1 Q. Are you able to quantify how many of your
2 well-intentioned prescriptions would have been diverted
3 by your patients?

4 A. No, and again, I don't have definitive proof
5 that they were, and usually it was, you know, in
6 retrospect. So I can't quantify that.

7 Q. All right. Romanette 9 on page 111.

8 MR. CRAWFORD: Hey, Ed, I think there
9 is, like, 40 minutes left. Just a heads-up.

10 MR. CARTER: Okay. I'll wrap up here,
11 Kyle. Thank you.

12 BY MR. CARTER:

13 Q. Romanette 9.

14 A. Yes.

15 Q. You wrote, "The absence of red flags for
16 opioids plus benzodiazapines and for the trinity of
17 those two drugs plus a muscle relaxer is a significant
18 omission that failed to properly instruct Walmart's
19 pharmacists as to both the potential for diversion,
20 since the drugs were known to increase the high among
21 drug users and the increased risks of medical
22 complications, especially the synergistic effects on
23 respiratory depression which were known to increase the
24 risk of overdose and death well before 2009."

25 Is it your testimony that that was an

1 intentional omission?

2 A. It is my testimony that Walmart and other
3 pharmacy defendants could have done more and chose not
4 to.

5 Q. And is it your testimony that that topic was
6 not addressed by Walmart pharmacist training outside
7 the POMs?

8 A. It's my testimony that Walmart failed to make
9 that combination a red flag, thereby triggering
10 pharmacists to investigate.

11 Q. Last topic, and then I'm going to hand off to
12 other Counsel. Do you agree that pharmacists have
13 sources of information beyond policies from their
14 chains?

15 A. Yes.

16 Q. Do you agree that pharmacists have
17 professional knowledge, training, and experience that
18 they get separate and apart from any support of their
19 managing chains?

20 A. Yes, but my impression is that a lot of their
21 training is organized by the managing chains.

22 Q. And you agree that pharmacists have
23 professional knowledge and training beyond, for
24 example, in the case of Walmart, the POMs?

25 A. Yes.

1 Q. So pharmacist's exercise of professional
2 judgment and skill is not limited to what is written in
3 an official corporate policy, fair?

4 MR. ARBITBLIT: Object to form.

5 THE WITNESS: I think their ability to
6 exercise their professional judgment is going to be
7 very strongly influenced by what is in the POM and what
8 they're incentivized to do.

9 BY MR. CARTER:

10 Q. My question was, is there exercise of
11 professional judgment and skill limited to what is
12 written in an official corporate policy?

13 MR. ARBITBLIT: Objection. Asked and
14 answered.

15 THE WITNESS: I think I answered that.

16 BY MR. CARTER:

17 Q. Is it your testimony to the jury that if it's
18 not in a corporate policy, a Walmart pharmacist or a
19 Walgreens pharmacist or any other chain defendant
20 pharmacist doesn't know what to do?

21 MR. ARBITBLIT: Objection. Misstates
22 the testimony.

23 THE WITNESS: My testimony --

24 BY MR. CARTER:

25 Q. I want to be clear; I'm asking a separate

1 question. Is it your testimony to the jury that if
2 it's not in a corporate policy, the chain defendant
3 pharmacists don't know what to do?

4 MR. ARBITBLIT: Object to form.

5 THE WITNESS: Again, I would say that
6 the corporate chain policy has a huge impact on what
7 pharmacies -- pharmacists will do. And there may be
8 other sources of knowledge, but they will be less
9 influential than the pharmacy chain policy, the
10 management, and the various incentive plans that are in
11 place.

12 BY MR. CARTER:

13 Q. Last question, on page 118 of your report, you
14 quote, in romanette 27, an email that is quoted in a
15 ProPublica story, and it's the last two words of
16 romanette 27, a reference to driving sales. Do you see
17 that?

18 A. Yes.

19 Q. Do you know that the individual who offered
20 that email was deposed in this litigation?

21 A. No. I didn't know that.

22 Q. If the author of that email was testifying
23 under oath about that email, would that be relevant
24 information that you would want to consider in forming
25 your opinion?

1 A. I would certainly be happy to read the
2 deposition or the testimony of that individual. It
3 doesn't negate what is here, what was written and what
4 was quoted.

5 Q. And you haven't conducted that review to this
6 point, correct?

7 A. That's correct.

8 MR. CARTER: All right, I yield to Kyle.

9 EXAMINATION

10 BY MR. CRAWFORD:

11 Q. Dr. Lembke, my name is Kyle Crawford, and I'm
12 Counsel for the CVS defendants.

13 On page 6 of your report you write,
14 "Throughout my career I have interacted with pharmacies
15 and pharmacists thousands of times."

16 Is that true today?

17 A. What do you mean? Is what true today?

18 Q. Is it true that you've interacted with
19 thousands of pharmacies and pharmacists throughout your
20 career?

21 A. Yes, I think that's true. I've interacted
22 with -- I have a long career. I've interacted with
23 many pharmacists and pharmacies.

24 Q. And did you interact with thousands of
25 pharmacies and pharmacists before 2019?

1 A. Yes. That's the cumulative interactions over
2 a 25-plus-year career.

3 Q. Would a prescription opioid epidemic have
4 existed if Purdue did not market opioids?

5 A. That's hard to say. Certainly Purdue was a
6 major player in creating the paradigm shift which led
7 to increased prescribing, which led to the opioid
8 epidemic. Whether or not other defendants -- I believe
9 even in the absence of Purdue's role, it's possible and
10 likely that the other defendants would have taken a
11 similar role, but it's hard to say.

12 Q. Would a prescription opioid epidemic have
13 existed had manufacturers did not market opioids?

14 A. I do think the marketing of opioids by opioid
15 manufacturers was a major factor in the creation of the
16 opioid epidemic. It's hard for me to say one way or
17 the other if the distributors' culpability and the
18 pharmacies' culpability independent of that would have
19 created the opioid epidemic. I think everybody in the
20 supply chain contributed to the opioid epidemic.

21 Q. Can you name any other company that
22 contributed more to the opioid epidemic than Purdue?

23 A. In terms of opioid manufacturers, certainly
24 Purdue was the major player, but I also think that the
25 distributors and the pharmacies played a huge role.

1 Q. If the standard of care around treating pain
2 had not become more liberal in the 1990s and 2000s,
3 would there have been a prescription opioid epidemic?

4 MR. ARBITBLIT: Object to form.

5 BY MR. CRAWFORD:

6 Q. You can answer.

7 A. Can you state the question again or rephrase?

8 Q. If the standard of care around treating pain
9 had not become more liberal in the 1990s and 2000s,
10 would there have been a prescription opioid epidemic?

11 MR. ARBITBLIT: Object to form.

12 THE WITNESS: Well, the -- the changes
13 in the way that opioids were prescribed in the late
14 1990s and the 2000s represent the paradigm shift that
15 was influenced by many factors, including significantly
16 the opioid pharmaceutical industry. Without the
17 influence of the opioid pharmaceutical industry, I
18 don't believe that the opioid epidemic would have
19 occurred.

20 BY MR. CRAWFORD:

21 Q. Would a prescription opioid epidemic have
22 existed if doctors did not overprescribe prescription
23 opioids?

24 MR. ARBITBLIT: Object to form.

25 THE WITNESS: Again, I don't think it's

1 possible to look at this problem in isolation. There
2 are many individuals and many entities to blame, and
3 everybody played their part and contributed to the
4 opioid epidemic.

5 BY MR. CRAWFORD:

6 Q. Has the CVS pharmacy ever called you or your
7 office to inquire about a controlled substance
8 prescription?

9 A. Yes.

10 Q. Approximately how many times?

11 A. Many times. I really can't count.

12 Q. And do you know if any CVS pharmacy has
13 refused to fill one of your prescriptions?

14 A. Yes.

15 Q. Do you know how many times?

16 A. I'm recalling one instance where a CVS
17 pharmacy was concerned with the way that one of my
18 patients was presenting to pick up her prescription and
19 as a result did not dispense to that patient. The
20 pharmacist called me and let me know.

21 Q. Before issuing this expert report, had you
22 ever stated that CVS specifically contributed to an
23 opioid epidemic?

24 A. I don't believe I've named CVS specifically,
25 except in this expert report, obviously.

1 Q. Do you have any personal knowledge of any CVS
2 pharmacist not properly exercising corresponding
3 responsibility?

4 MR. ARBITBLIT: Object to form.

5 THE WITNESS: Yes.

6 BY MR. CRAWFORD:

7 Q. Setting aside -- are you thinking of a
8 specific instance, or are you thinking of aggregate --
9 your knowledge about what happened at the aggregate
10 level?

11 A. Specific and aggregate.

12 Q. What's the specific instance in which CVS
13 pharmacists did not properly exercise their
14 corresponding responsibility?

15 A. I have done many assessments of
16 prescription -- prescription drug monitoring database
17 in California and seen patients of mine who were
18 dispensed multiple prescriptions for the same or
19 similar substances, dispensed dangerous combinations in
20 very high doses for long durations, patients who were
21 engaging in doctor shopping and pharmacy shopping,
22 early refills, including at CVS pharmacies. That's
23 suggesting that the pharmacy did not do their due
24 diligence to properly investigate red flags.

25 Q. Did any of this occur in Lake or Trumbull

1 County?

2 A. So I practice in California, so my specific
3 examples are California, but again, I have no reason to
4 think that things are different in Lake and Trumbull
5 County.

6 Q. Did CVS have signs in its store promoting
7 prescription opioids?

8 A. If you give me one moment.

9 MR. CRAWFORD: If this is going to take
10 a few moments, let's go off the record.

11 THE VIDEOGRAPHER: We are going off the
12 record at 4:11.

13 (Discussion off the record.)

14 THE VIDEOGRAPHER: We are back on the
15 record. The time is 4:11.

16 THE WITNESS: On page 78 of my report I
17 discuss how CVS CareMark promoted opioid products using
18 targeted endorsements, including a pharmacy literature
19 display to educate patients by literature located
20 adjacent to prescription counter.

21 BY MR. CRAWFORD:

22 Q. Dr. Lembke, you're aware that you're citing a
23 document that lists potential literature, aren't you?
24 Are you aware of any actual signs in CVS stores
25 promoting opioids?

1 A. Well, again, I -- I haven't seen anything to
2 refute that CVS engaged in these collaborations with
3 opioid manufacturers to promote specific products at
4 the counter.

5 Q. Dr. Lembke, what did the signs say in CVS
6 stores that promoted opioids?

7 A. Again, on page 79, CVS promoted the
8 opportunity to advertise specific direct-to-consumer
9 advertising of specific products on --

10 Q. Move to strike.

11 My question is what did the sign say, not was
12 there an opportunity for there to be signs, was there a
13 possibility. If you don't know what the sign said,
14 that's fine, and we can move on.

15 A. Yeah, I'm not sure what the sign said.

16 Q. Did CVS ever pay key opinion leaders?

17 A. Not that I'm finding.

18 Q. Did CVS ever pay medical schools to influence
19 curriculum regarding the treatment of pain?

20 A. Not that I know of.

21 Q. Does CVS employ sales representatives who
22 marketed prescription opioids to doctors?

23 A. CVS collaborated with opioid manufacturers,
24 sales representatives, and other entities like Partners
25 Against Pain and JCAHO, but as far as I know they did

1 not employ their own drug reps.

2 Q. Have you reviewed the contents of any
3 continuing education presented to CVS pharmacists?

4 Let me withdraw the question; ask it
5 differently. Are you aware of any false statements
6 contained in continuing education classes that CVS
7 provided its pharmacists about prescription opioids?

8 A. Just give me a moment. Not that I'm able to
9 identify right now.

10 Q. You mentioned earlier CVS's prescriber
11 monitoring program. Do you recall that?

12 A. Can you tell me --

13 Q. Let me try and ask -- all right. You
14 mentioned earlier a CVS prescriber monitoring program,
15 and I'll represent to you that that's a program in
16 which CVS decides whether to suspend pharmacies for
17 filling the prescriptions of certain doctors. Do you
18 recall that?

19 A. Yes.

20 Q. Is that kind of program required by law?

21 A. No.

22 Q. Would you agree that CVS's prescriber
23 monitoring program was a helpful tool?

24 MR. ARBITBLIT: Object to form.

25 THE WITNESS: Are you specifically

1 referring to the 2014 policy on page 128 of my report?

2 BY MR. CRAWFORD:

3 Q. I'm asking -- you're opining in your opinion
4 that CVS failed to have effective controls against
5 diversion, correct?

6 A. Yes.

7 Q. All right. And my question is, was CVS's
8 prescriber monitoring program a helpful tool in -- let
9 me -- let me rephrase.

10 Was the CVS prescriber monitoring program a
11 helpful tool that contributed to CVS in fact having
12 some effective controls against diversion?

13 A. Yes.

14 Q. And in your opinion you state that CVS could
15 have implemented this program 15 years earlier,
16 correct?

17 A. Yes.

18 Q. And what's the basis of your opinion that CVS
19 could have implemented this program in the year 2000?

20 A. Because CVS would have had this data.

21 Q. Are you offering an opinion that it would have
22 been technically feasible to create this program in the
23 year 2000?

24 A. Maybe not the year 2000, but I believe it
25 would have been technically feasible earlier than 2014.

1 Q. You've never designed an algorithm to identify
2 prescribers --

3 (Reporter clarification.)

4 A. I'm sorry. Could you say that again?

5 Q. Let me withdraw the question. Aside from CVSs
6 prescriber monitoring program, has CVS done anything
7 helpful to combat the opioid problem?

8 A. Yes, I do believe CVS has taken some measures
9 to combat the opioid problem.

10 Q. What are those measures?

11 A. Over time, in an iterative process, CVS did
12 change its policies and procedures regarding red flags
13 in their investigation.

14 Q. Anything else?

15 A. I believe that CVS has also sponsored some
16 drug take-back days. I believe CVS also may have
17 participated in improving access to Naloxone.

18 Q. Anything else?

19 A. Not outside what's in my report.

20 Q. Are you aware that CVS uses data to analyze
21 dispensing trends of its pharmacies?

22 A. Yes.

23 Q. And would that also be something that you
24 would say was helpful for CVS to have done?

25 A. Yes.

1 MR. ARBITBLIT: Object to form.

2 BY MR. CRAWFORD:

3 Q. All right. Are you aware that CVS also
4 monitors patients receiving high doses and high MMEs of
5 prescription opioids?

6 A. I believe that is a later change, but I'm not
7 sure.

8 Q. Aside from relying on plaintiffs' Counsel to
9 provide you with documents, did you do anything else to
10 determine whether CVS had effective controls against
11 diversion?

12 MR. ARBITBLIT: Object to form.

13 THE WITNESS: Yes. I mean, I
14 investigated the medical literature. Again, in my
15 research for my book, I talked to pharmacists. So it
16 wasn't just me relying on the documents provided by
17 Counsel. I also used my education, experience, medical
18 literature, the available reports.

19 BY MR. CRAWFORD:

20 Q. How many CVS pharmacists have you talked to in
21 preparing this expert report?

22 MR. ARBITBLIT: Object to form.

23 THE WITNESS: I've talked to many CVS
24 pharmacists over the years. I didn't specifically
25 reach out to a single CVS pharmacist while preparing

1 this report, but I had already had many interactions
2 and encounters with CVS pharmacists over many years.

3 BY MR. CRAWFORD:

4 Q. Were any of them working in Ohio?

5 A. Not as far as I'm aware. No.

6 MR. CRAWFORD: Let's go off the record.

7 THE VIDEOGRAPHER: We are going off the
8 record at 4:23.

9 (Discussion off the record.)

10 THE VIDEOGRAPHER: We are back on the
11 record. The time is 4:27. Please proceed.

12 (CVS Exhibit 1 marked for identification.)

13 BY MR. CRAWFORD:

14 Q. All right, Dr. Lembke, I'm marking as CVS
15 Exhibit 1 a two-page document entitled "How to Stop
16 Drug Diversion and Protect Your Pharmacy."

17 Do you see this document?

18 A. Yes, I do.

19 Q. And I'll represent -- well, and do you see at
20 the bottom of the document it's dated 2001?

21 A. 2001 Purdue Pharma LLP.

22 Q. Yes. Have you reviewed this document?

23 A. I probably have. It looks similar to many
24 documents that I reviewed, but I don't know if I've
25 reviewed this specific one.

1 Q. You just reviewed the document off the record?

2 A. Oh, yes, I just reviewed it here. I thought
3 you meant prior to today's testimony.

4 Q. Are there any false statements contained in
5 this brochure?

6 MR. ARBITBLIT: Object to form.

7 THE WITNESS: No. But this is only a
8 portion of the document, so hard to say if the document
9 itself contains false statements, but I don't see
10 anything in these two pages that you've given me.

11 BY MR. CRAWFORD:

12 Q. I'll represent to you that this is the
13 entirety of the brochure entitled "How to Stop Drug
14 Diversion and Protect Your Pharmacy."

15 MR. CRAWFORD: That's all I have. I'll
16 pass the witness.

17 EXAMINATION

18 BY MS. GIBSON ALLEN:

19 Q. Good afternoon -- evening, Dr. Lembke. Hi, my
20 name is Erin. We met briefly at the beginning of your
21 deposition. I represent Giant Eagle, a defendant in
22 this litigation.

23 Have you ever had occasion to visit the Giant
24 Eagle?

25 A. No.

1 Q. So you've never interacted with a Giant Eagle
2 pharmacist?

3 A. No.

4 Q. And you're aware that Giant Eagle is not a
5 national pharmacy?

6 A. Yes.

7 Q. I'd like to ask you a question about an
8 opinion you have on page 93 of your report in
9 romanette 33. And I believe romanette 33 falls under
10 the heading "Pharmacy defendants spread misinformation
11 about the safety and efficacy of opioids," correct?

12 A. Yes.

13 Q. And on page 93 in romanette 33 you reference a
14 series of internal Purdue emails from the year 2000; is
15 that correct?

16 A. Yes.

17 Q. Those are 21 years old; is that correct?
18 21-year-old emails from Purdue?

19 A. Yes.

20 Q. Thank you. And you reference that in those
21 emails, Purdue sales representative says that they
22 worked contacts at Giant Eagle to initiate a mailing,
23 something called 550 Littmann CEs, which you have in
24 parens, are continuing education program materials, and
25 then your report goes on to describe what the emails

1 say.

2 Have you reviewed any evidence in this case
3 indicating that Giant Eagle ever distributed the
4 Littmann continuing education materials to its
5 pharmacists?

6 A. No, but I have no evidence to the contrary.

7 Q. You have no evidence either way; you just have
8 these 21-year-old Purdue emails, correct?

9 A. That's correct.

10 Q. I'd like to take you now to page 155 in your
11 report. In romanette 2 on page 155 you mention that
12 "Giant Eagle did not adopt a controlled substance
13 dispensing guideline policy until July 22, 2013." Is
14 that correct?

15 A. Yes.

16 Q. Did you review any testimony or evidence in
17 this case regarding what policies or procedures Giant
18 Eagle pharmacists had access to, either physically in
19 their stores or online before 2013?

20 A. Can you just give me a moment?

21 Q. Uh-huh.

22 A. So I did evaluate a number of documents, for
23 example, December of 2011 I evaluated a settlement
24 agreement with the Ohio Board of Pharmacy related to
25 Giant Eagle's failure to deter and detect the theft and

1 diversion of controlled substances at its Chardon, Ohio
2 pharmacy. I also reviewed documents from 2012 and --
3 showing that Giant Eagle pharmacists were incentivized
4 with a bonus plan if they prescribed larger number of
5 units to patients who came into Giant Eagle pharmacies.

6 Q. So I appreciate that you reviewed some other
7 documents relating to Giant Eagle. My question,
8 though, was not that. My question was did you review
9 any testimony or evidence in this case regarding the
10 policies or procedures that a pharmacist would have
11 access to in their stores in their stores physically or
12 online prior to 2013? That would be a simple yes or
13 no.

14 A. Yeah, the answer is no.

15 Q. Thank you. I wanted to ask you a question
16 also about you reference on the next page in subheading
17 5 which you just mentioned, Giant Eagle's bonus plan.
18 Have you seen any evidence in this case about what
19 percentage that bonus comprises of the overall annual
20 salary of the Giant Eagle pharmacist?

21 A. If I have, I don't remember.

22 Q. Okay, thank you.

23 And Dr. Lembke, are you familiar with any
24 limitations in the regulation establishing Ohio's PDMP
25 as to whether, and there are certain circumstances as

1 to who, and under what circumstances someone is
2 permitted to access OARRS, the OARRS database?

3 A. So my understanding of the regulations
4 regarding the OARRS database is that in 2011 there were
5 regulations that mandated that a pharmacist check the
6 OARRS database if they detected certain red flags. But
7 as I've written here and as I've testified, that was
8 backwards because, in fact, checking the database a
9 priority is the way to detect red flags in the first
10 place.

11 Q. Right, but again, that wasn't my question. My
12 question was are there limitations on who and under
13 what circumstances OARRS can be accessed. So for
14 example, is it appropriate for a pharmacist to access
15 OARRS to check to see if their neighbor, because
16 they're curious, has had controlled -- prescriptions
17 for controlled substances filled?

18 A. No, that would be a HIPAA violation.

19 Q. Okay. And so would it be appropriate for a
20 pharmacist to check OARRS if they were curious about a
21 co-worker or if somebody else had had a prescription
22 for a controlled substance filled?

23 A. No. That would not be appropriate.

24 Q. So it is appropriate to have some limitations
25 on when a pharmacist can or cannot access OARRS,

1 correct?

2 A. Well, those limitations are for people who are
3 not interacting with pharmacists in their professional
4 capacity. But in your professional capacity, I can't
5 think of any limitation that would make sense for why a
6 pharmacist wouldn't check the PDMP when the PDMP is
7 among single most important things that can be checked
8 to prevent misuse and diversion.

9 Q. Thank you. Is it ever appropriate to
10 prescribe a benzodiazapine for a patient who is also
11 taking opioid medications?

12 A. There are certain instances and certain
13 treatment settings where that is appropriate, yes.

14 Q. And is it ever appropriate to dispense a
15 benzodiazapine for a patient who is also on opioids?

16 A. I'm sorry, is that different from the last
17 question?

18 Q. One was regarding prescribing and one was
19 dispensing.

20 A. Yes, in some rare instances it is appropriate
21 to dispense.

22 MS. ALLEN: That's the end of my
23 questions. I think there are three minutes left, by my
24 math. I don't know if any of my co-counsel has a
25 follow-up question and would like to use those last

1 three minutes.

2 THE VIDEOGRAPHER: Sounds like there is
3 nothing further for the record?

4 MR. GISLESON: Can we go off the record
5 and tell me how much time we have left?

6 THE VIDEOGRAPHER: She is correct, three
7 minutes, but we can go off the record. Are we going
8 off the record just for the moment or for the day?

9 MR. GISLESON: We can go back on the
10 record.

11 EXAMINATION

12 BY MR. GISLESON:

13 Q. Dr. Lembke can you get your book, please,
14 "Drug Dealer M.D." and turn to page 126.

15 A. Mr. Gisleson, I can't see you.

16 Q. You're better for it.

17 Can you turn to page 126, please. Under the
18 heading, "Practicing with blinders on, not Toyota after
19 all?" You wrote, "Good communication between doctors
20 today is essentially to good care. Most patients have
21 more than one doctor taking care of them, or they
22 change doctors frequently due to insurance changes and
23 other provisions of the managed care environment. Each
24 doctor is busy prescribing the pills he or she believes
25 will treat the patient while other doctors are

1 prescribing other pills. It is entirely commonplace to
2 encounter a patient who is getting a stimulant from a
3 psychiatrist --

4 (Reporter clarification.)

5 Q. You wrote, "Most patients have more than one
6 doctor taking care of them, or they change doctors
7 frequently due to insurance changes or other provisions
8 of the managed care environment. Each doctor is busy
9 prescribing the pills he or she believes will treat the
10 patient while other doctors are prescribing other
11 pills. It is entirely commonplace to encounter a
12 patient who is getting a stimulant from a psychiatrist
13 for attention deficit disorder, an opioid painkiller
14 from a pain doctor for fibromyalgia, and a
15 benzodiazapine from a primary care doctor for sleep."

16 That's consistent with your research and
17 experience in terms of that being entirely commonplace,
18 correct?

19 A. It being entirely commonplace does not make it
20 right.

21 Q. And lastly, are you familiar with the
22 Substance Abuse and Mental Health Services
23 Administration?

24 A. Yes.

25 Q. Do you consider their published materials to

1 be the kind of materials on which professionals in the
2 substance abuse field rely?

3 A. It would depend on the publication you were
4 talking about.

5 Q. Do you agree with the statement, "PDMP data
6 are best used in conjunction with other sources of
7 information, including clinical assessment before
8 making any determination about aberrant behavior
9 because no validated and standardized criteria for the
10 threshold of questionable activity have been
11 established"?

12 MR. ARBITBLIT: Object to form.

13 THE WITNESS: I'd like to review that
14 document.

15 MR. GISLESON: Why don't we go off the
16 record.

17 MR. ARBITBLIT: We're not going off the
18 record, Counsel, unless we're done. You've used your
19 time.

20 MR. GISLESON: She wants to review the
21 document.

22 Matt, can you show her, please, what was in
23 Tab 8 and mark that as the next exhibit?

24 THE WITNESS: Is there more time or are
25 we out of time?

1 MR. ARBITBLIT: We're out of time, but
2 I'm going to allow this last question since you asked
3 to review the document.

4 MR. LADD: Tab 8 is being marked as
5 Lembke Exhibit 4.

6 (Exhibit 4 marked for identification.)

7 BY MR. GISLESON:

8 Q. You reviewed this SAMHSA In Brief?

9 A. I'm sorry, is this in the documents that were
10 sent to me?

11 Q. Yes, I'm sorry, Tab 8.

12 A. Okay.

13 MR. SHERIDAN: While she's looking, may
14 I request that the pending question be reread?

15 THE WITNESS: Yes, could you reread the
16 question to that I know why I'm looking at this
17 document?

18 BY MR. GISLESON:

19 Q. The first question was have you reviewed this
20 SAMHSA In Brief?

21 A. Okay, and what came after that?

22 Q. And the next question is, which I asked you
23 before, to give it context, if you go to the fourth
24 page, the first full paragraph on the left-hand column
25 says, "Behavior that suggests substance misuse, a

1 substance use disorder, or a diversion is known as
2 aberrant drug-related behavior. PDMP data can alert a
3 practitioner to aberrant behavior such as doctor
4 shopping, obtaining overlapping prescriptions from
5 different doctors for intended non-medical use, or
6 pharmacy shopping, visiting multiple pharmacies to fill
7 multiple prescriptions. These are called multiple
8 provider episodes. PDMP data are best used in
9 conjunction with other sources of information,
10 including clinical assessment before making any
11 determinations about aberrant behavior because no
12 validated and standardized criteria for the threshold
13 of questionable activity have been established."

14 Do you agree with what is written there by the
15 Substance Abuse and Mental Health Services
16 Administration?

17 A. I'm going to review the document now. Okay,
18 I'm ready to respond.

19 Q. Do you agree with what the Substance Abuse
20 Administration wrote that I just read to you?

21 A. Yes. Are we back on the record?

22 Q. Yes.

23 A. Okay. So what you read to me was taken out of
24 context. The section that you read is clearly directed
25 towards practitioners and prescribers, not pharmacists.

1 The section that follows and proceeds is directed
2 towards pharmacists, so -- and I think what is
3 important to emphasize that this document makes it very
4 clear that both prescribers and pharmacists should be
5 checking the PDMP consistently in order to prevent
6 misuse and diversion.

7 Prescribers and pharmacists have access to
8 different types of information, and the statement here,
9 which you specifically point out that "the PDMP data
10 are best used in conjunction with other sources of
11 information" is directed to prescribers in this
12 document. For example, the very next item is including
13 a clinical assessment, so a clinical assessment is done
14 by a prescriber, not by a pharmacist.

15 And furthermore, the document does cite to
16 some attempt here to quantify proposed operational
17 definition, for example, written by different
18 prescribers and filled at three or more pharmacies.
19 But most importantly, this section is directed towards
20 prescribers. The statement you identified is directed
21 towards prescribers, and what follows at the bottom of
22 that same page is the statement "not only prescribers
23 but also pharmacists are enhancing patient care through
24 their use of the PDMP. For example, pharmacists can
25 identify interaction risks from multiple prescriptions.

1 Pharmacists can also initiate conversations with
2 patients whose prescriptions use patterns indicate
3 possible substance misuse," et cetera, et cetera.

4 So what this document stands for is that both
5 prescribers and pharmacists should be checking the PDMP
6 to prevent misuse and diversion.

7 Q. And you agree with the statements, then, in
8 this document?

9 MR. ARBITBLIT: We're done, Counsel you
10 had your last question. We're done.

11 MR. GISLESON: She hadn't answered the
12 question.

13 BY MR. GISLESON:

14 Q. Do you agree with the statements in the
15 document, Doctor?

16 A. I answered your question.

17 Q. No, you didn't. Do you agree with the
18 statements in the document?

19 MR. ARBITBLIT: She said she has
20 answered it. We're done.

21 MR. GISLESON: She hasn't.

22 MR. ARBITBLIT: That's your opinion.
23 You've stated that several times. You mislead her, she
24 answered that you misled her, and we're done.

25 MR. GISLESON: Actually, that's false,

1 as you know, because that's in the section entitled,
2 "How prescribers and pharmacists use PDMP data." It's
3 unfortunate that Dr. Lembke chooses not to ask -- or
4 chooses not to answer directly questions that she is
5 asked. If you're instructing that the deposition is
6 over and that she is unwilling, unable, or for what
7 whatever other reason won't answer the question, well,
8 then that's fine.

9 MR. ARBITBLIT: I think she's answered
10 the question. She thinks she's answered the question.
11 We're done.

12 MR. GISLESON: Thank you for your time.
13 It's been a pleasure.

14 THE VIDEOGRAPHER: Thank you. One
15 moment, please. This concludes today's testimony given
16 by Dr. Anna Lembke. The total number of media units
17 used was five. All media will be retained by Veritext
18 on a local secure drive and redundantly stored in the
19 Veritext-managed Amazon cloud S3 services for
20 preservation purposes. We are off the record at 4:52.
21 Thank you.

22 (Signature reserved.)

23 (Deposition concluded at 4:52 p.m. PDT)

REPORTER'S CERTIFICATE

I, JUDY BONICELLI, the undersigned Certified Court Reporter, pursuant to RCW 5.28.010 authorized to administer oaths and affirmations in and for the State of Washington, do hereby certify:

That the sworn testimony and/or proceedings, a transcript of which is attached, was given before me at the time and place stated therein; that any and/or all witness(es) were duly sworn to testify to the truth; that the sworn testimony and/or proceedings were by me stenographically recorded and transcribed under my supervision, to the best of my ability; that the foregoing transcript contains a full, true, and accurate record of all the sworn testimony and/or proceedings given and occurring at the time and place stated in the transcript; that I am in no way related to any party to the matter, nor to any counsel, nor do I have any financial interest in the event of the cause.

WITNESS MY HAND and DIGITAL SIGNATURE this 17th day of November, 2017.



JUDY BONICELLI, RPR, CCR

Washington Certified Court Reporter, CCR 2322

Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

June 3, 2021

To: DONALD C. ARBITBLIT

Case Name: National Prescription Opiate Litigation - Track 3 v.

Veritext Reference Number: 4611739

Witness: Anna Lembke, M.D. Deposition Date: 5/28/2021

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4611739

National Prescription Opiate Litigation - Track 3 v.

DATE OF DEPOSITION: 5/28/2021

WITNESS' NAME: Anna Lembke, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

Date

Anna Lembke, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;

They signed the foregoing Sworn Statement; and

Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of _____, 20____.

Notary Public

Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4611739

National Prescription Opiate Litigation - Track 3 v.

DATE OF DEPOSITION: 5/28/2021

WITNESS' NAME: Anna Lembke, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

Date

Anna Lembke, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;

They have listed all of their corrections in the appended Errata Sheet;

They signed the foregoing Sworn Statement; and

Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal
this _____ day of _____, 20____.

Notary Public

Commission Expiration Date

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ERRATA SHEET
VERITEXT LEGAL SOLUTIONS MIDWEST
ASSIGNMENT NO: 4611739

PAGE/LINE(S) / CHANGE /REASON

Date Anna Lembke, M.D.
SUBSCRIBED AND SWORN TO BEFORE ME THIS _____
DAY OF _____, 20____ .

Notary Public

Commission Expiration Date

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

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